Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Adelaide Rebecca Tucker Physician/ **December** 18, 2010 0345 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Homewood at Crumland Farms Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🅿 F Months Days Hours (Month, Day, Year) **June 1, 1925 8**5 220-16-3205 Director Maryland Usual Residence of Decedent i and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. or 28a-f show 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Director Frederick Maryland Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 21702 Funeral 7407 Willow Road United States of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates er than "natur the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Ruth Winpigler 0 Guy Thomas Smith 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code)

13825 Wolfsville Road, Smithsburg, Maryaind 21783 Mary Ann Putman / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If ite December 21, 5 1 X Burial 2 Cremation 3 Removal from State Resthaven Memorial Gardens 2010 Frederick, Maryland injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicer Reeney & Bastord F.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition resulting in death) Onset and Death *Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year Yes Unkr ate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of performe 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to Be 26. Place of Death (Check only one) examiner? Other: 2 100 ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 1 🗌 Yes 2 \square No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: Ja the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16428 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 300 West Ninth Street, Frederick, Maryland 21701 Casper E. Cline, III, M.D. 31. Date filed (Month, Day, Year, . Registrar's Signature State JAN Registrar

DHMH 17 Rev 7/2009

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			1 - For State Registrar		laryland / Dep <i>Ce</i>	artment of F		1	Reg. No.	010	1	0
Г	Physic		Decedent's Name (First, Middle, JAMES	RICHARD	WEDGE			2. Date of Dea		2010	3. Time of E	Death A M
	/Medi Exami		4a. Facility Name (If not institution, 6804 FOREST	TERRACE		4b. City, Town, o	R	ath	4c. Cou	nty of Death		
k	Funeral Director		217-42-9988	6. Sex 7. A 1 _ X M 2 ☐ F	ge (In yrs. last birthday, 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		h 7, <i>Year)</i> 1948	9. Birthr	place (State or try) LAND	Foreigr
	Maryland a-f show fied at	ctor	Usual Residence of Decedent	GEORGE'S	10c. City, Town or Le					1	0d. Inside City	
	with the	I Dire	10e. Street and Number 6804 FOREST TE	RRACE		10f. Zip Code 20785			10g. Citizen o	of What Cour	ntry?	
920	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	10 111 0 1	No ATETHAL	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗓 No		(Specify Yes or No- erto Rican, etc.)		lace - Americ lack, White, cify: BL	etc.	
21215-0036	filed within 72 ho Hygiene. other than "natul ent, the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 11TH	s Education grade completed) College (1-4or	(Give life.	dent's Usual Occup kind of work done DO NOT use retired REHOUSEMA	during most of w i)	vorking		6b. Kind of Business/Industry PRIVATE		
Maryland 2	2 should be filed n and Mental Hyg is marked other raumatic event, i	To Be C	17. Father's Name (First, Middle, L JAMES EDWARD WE	•	1		18. Mother's N	ame (First, Middle, RICE BOWE	Maiden Surn		-41.	
	1 and 2 shor Health and M em 27 is ma other trauma		19a. Informant's Name/Relationshi JUANITA WEDGE/			ng Address (Street FOREST T					0 Code) 0785	
Baltimore,	permit. Pages 1 and Department of Healtl Important: If item 27 any injury or other 1 once.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L.)		MD VETER	osition (Name of matory or other place ANS CEMET 2. Name and Addre 7474 LAND	ERY 12/	J. B. JEN	KINS F	HAM,M UNERA	ARYLAND L HOME,	INC
8760,	Table 1 is the death certificate be executed and in the death certificate be executed as specificate by the attending physician and a should be detached for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter this derlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	Inc. ALL CELL LU s a consequence of): s a consequence of): s a consequence of):			ac or respiratory ar	rest,		Approximate Interval Between Onset and De	een aath
.O. Box 6	that the death certific led by the attending p detached for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)	,		- 1	Date of delive	,	ear
<u>α</u>	ires that signed b	by	Part II. Other significant condition DIABETES MELLI	-	•	nderlying cause give	en in Part I.				ne cause of de	
Il Records,	The ate has page	Completed						24a. Was a	an 24	b. Were auto	psy findings averaged from the second	vailable
Division or Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident 3 Suicide 4 Homicide 6 Could no determin	28a. Date of Inj (Month, Date of Inj to be ed 28e. Place of in building, e	ijury - At home, farm, str. (Specify)	f 28c. Injur Worl M 1 □ reet, factory, office	er: 4 Nursing y at k? Yes 2 No	eath (Check only on Home 5 X Residence 28d. Describe home 28f. Location (San City or Town ce, and due to the control of the co	lence 6 Co	urred mber or Rura manner as s	il Route Numbe	er,
	To the Ho within 24 To the Fu	Medical	(Check only 2 ☐ Medical E	xaminer: On the basis of and manner's	of examination and/or in tated.	29c. License	e number		date and place 29d. Date sign	ned (Month,	Day, Year)	
	El.		30. Name and address of person w	STONE, M.D.	, VAMC 50	ŕ	REET NW,	, WASHING	TON, DC	20422	2/688	
DHI	Sta Registi MH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year) DEC 1 5 2016	32. Regist	rar's Signature							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 2010 2:00pm M Irene Ives Boone Warnlof 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village Montgomery Victoria Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Ye 20, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🕱 F Hours Year 1920 Pennsylvania 167-18-5154 90 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No Maryland Montgomery Montgomery Village 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 20886 United States 9705 Inaugural Way 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married 1 Yes 2 No
If Yes, Give
Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 2 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ives May Blithe Robert Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9705 Inaugural Way, Montgomery Village, MD 20886 Otto K. Warnlof (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sunset Memorial Park 12/18/2010 4 Donation 5 Other (Specify) Feasterville, PA Signature of Funeral Service Licens Name and Address of Facility DeVol Funeral Home East Deer Park Drive ithersburg, MD 20877 Gaithersburg, . Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final TONIC disease or condition resulting in death) 4000 OMING Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of)

enysician/ Medical Examiner

> and burial-tran physician s the burial

attending p

ed by the a ted by t signe 1 be d

cate has by page 2 s certificate this

i 24 hours after death.

E Funeral Director: After this leted filled in by the funeral of

completed within 2

30. Name and address of person who

(Month, Day, Year)

14

Physician/

Medical

Director

Funeral

Completed by

Be

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10a. State

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

72 hours after death with the Maryland

(Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after decommit. Page 1 and 2 should be filed within 72 hours after decomparation of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examines once.

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examir	cause. Enter Underlying Cause (Disease or iinjury that initiated events							
	resulting in death) Last	Due to (or as a consequ	uence of):					
g		***						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		23d. Date of delivery Month Day Year					
	Part II. Other significant conditions conti	ributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e Did tobace	co use contribute to the cause of death?		
ompleted by	Alzheimers	2 No 3 ☐ Probably 4 ☐ Unknown						
<u>e</u>	endometric	al conce	2		24a. Was an	24b. Were autopsy findings available		
Comp	ischemic	heart a			autopsy performed 1 \(\sum \) Yes 2			
Be	25. Was case referred to medical			26. Place of Death (Che	eck only one)			
9	examiner? 1 Yes 2 No	spital: 1	ER/Outpatient 3	DOA Other: 4 Nursing H	Home 5 Residence	e 6 Dother (Specify) Group Home		
Certificate:	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 Yes 2 No		escribe how injury occurred		
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fact	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical	(Check 2 Medical Examine)	r: On the basis of examination	n and/or investigation,	at the time, date and place, a in my opinion, death occurred curred at the time, date and pl	at the time, date and pl	ace, and due to the cause(s) and manner stated.		
	29b. Signature and title of certifier		2	9c. License number	29d.	Date signed (Month, Day, Year)		

State

Registrar

Russell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) Year Month **Physician** Rita D. Wright 2010 3:25 P 10. Dec. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catherine's Nursing Home Emmitsburg Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex **Funeral** Days 1 □ M 2 1 150-10-2425 92 Director 30, 1918 New Jersey June Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanther must be notified at 1 Yes 2 No MD Frederick Director Emmitsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 331 S. Seton Avenue 21727 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White 3 ¥Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary D'Ermo Joseph Genovese ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. James Wright - Son 2126 Uniontown Rd., Westminster, MD 21158 20c. Location - City or Town. State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Cherry Hill, NJ 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home 21727 Approximate Interval Between Onset and Death 210 W. Main St., Emmitsburg, MD 23a Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardination, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death)) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1∐Yes 2⊠No P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Tyes 2 No 3 Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed this certificate 1 ☐ Yes 2 XNo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death I or Attending Patter death.

Director: After i After 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C

State Registrar

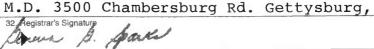
Rita B. Harrison, 31. Date filed (Month, Day, Year) DEC 1 3 2010

29a. Certifier

(Check only

29b. Signature and title of certifie

Medical



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Darke

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

PA 17325

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ RAY WILFONG Month 1550 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Rocky, lie - Grove Monta Advent oner If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2 □ F Min FEB 28, T 217-44-6710 Hours 64 946 **Director** Usual Residence of Decedent shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director MONTGOMERY 28a-f MD. GAITHERSBURG 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 218 ROLLING ROAD 20877 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE Specify "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and 2 should be filed within 73 Health and Mental Hygiene. Iem 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ISO QUALITY MANAGEMENT RAILWAY ELECTRONICS 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important; If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ RAY W. WILFONG, SR. ALDA BARR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN WILFONG- WIFE 218 ROLLING RD., GAITHERSBURG, MD. 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State METROPOLITAN CREM 12/16/10 1 Burial 2 X Cremation 3 Removal from State ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2 2 2 2 - WI SCONSIN 21. Signature of Funeral Service Licens 22 WASHINGTON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ severe disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Oronous Faculations if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death n signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 Alo 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 2 46 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at After t 1 Natural (Month, Day, Year) 5 Pending 1 \square Yes 2 🗀 No Accident Investigation hin 24 hours after deatl the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [3 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within To the 2 29c. License number 29d. Date signed (Month, Day, Year) WD 121 person who completed cause of death (Item 23a) (Type, Print) Suite = 2 Rockville, MD 20850

State Registrar

15400

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15225

MD

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Betty M. Wes 2 Date of Death Betty West Physician/ Dec. Day 2010 12. A^{M} 6:04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** April 18,1929 Charlotte, NC Days Hours Min. 1 □ M 2 XF 240-40-2254 81 Director Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 √ Yes 2 □ No Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1125 Urell Pl. NE 20017 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify Specify: **Black** "natural" Completed 3 XWidowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 DC Govt Registered Nurse traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Will Montgomery Minnie Samuels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Hayden/ Daughter 12207 Westview Dr. Upper Marlboro, MD 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/21/10 Waldorf, MD Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Pridgen Funeral Service, PA Mawaya 9013 Annapolis Rd. Lanham, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WKS Immediate Cause (Final Physician/ Urose sis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner wks Osteomyelitis Sequentially list conditions, if any, leading to immediate Cause (Disease or linjury Examiner Due to (or as a consequence of): End-stage Dementia the Hospital or Attending Physician; The law requires that the death certificate be executed and-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death has been signed by the e 2 should be detached q 🗍 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Unstageable pressure ulcers in sacral and thigh 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an areas, CVA, type 2 diabetes mellitus autopsy page certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after uccur.

To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) nances 0065 485 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		State	OI Wai yiai		tificat			and iv	Tomainy	Reg. No			
	Physicia	n/	1. Decedent's Name									2. Date of De Month		ZUI	'ear	3. Time of Death
	Medic Examin	al	Richard 4a. Facility Name (if		Whitak , give street and nu			4b. City,	Town, or	Location		Decem)		16,2 . County of		2:27P M
)		904 Ash					Ca	apit	ol H	leig					eorges
	Funeral Director		5. Social Security No. 241-52- Usual Residence of	5500	6. Sex 1 X M 2 □ F	7. Age (In yrs. I	ast birthday) 5 Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, Da June	rth B , 19	35	9. Birthpl Count NC	lace (State or Foreign ry)
	land show dat	tor	10a. State	10b. County		10c. Cit	ty, Town or Loc								10	Od. Inside City Limits
	Mary 28a-f	Director	MD		PG		Cap			ight	s					1 X Yes 2 No
	h with the	Funeral E	10e. Street and Nun					10f. Zip	20	743			Uni	itizen of Wh		
9	or iter		 Marital Status Never Marri 	ied 2 🗌 Mar	Armed Fried 1 \(\sum \) Yes	2 🔀 No	I					ecify Yes or No- Rican, etc.)	-		White, e	tc.
21215-0036	ours aff tural", al Exa	Completed by	3 XWidowed		1001 01					Specify:				Specify:	_	
215-	י 72 hc an "na Medic	mple	(Spe	cify only high	nt's Education est grade complete	d) (1-4 or 5+)	16a. Deced (Give H life. Do	ent's Usua aind of wo DNOT use	al Occupa rk done d e retired)	ation <i>uring mos</i>	t of worki	ing	16b. k	Kind of Busi	ness Ind	ustry
212	withir ygiene her tha t, the		6			(1-4 or 5+)	Mai	l De	eliv	erer	•		Wa	shin	gto	n Post
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at 200e.	To Be	17. Father's Name (I Richard		•	r					er's Name iah	e (First, Middle		Surname)		
Mar	12 shou alth and 27 is m ir traum		19a. Informant's Na Rita Wh			ter						n Road n Road		r Town, Stai	te, Zip C	ode)
Baltimore,	ge 1 and at of Hea it fitem or othe		20a. Method of Disp 1 🙀 Burial 2	☐ Cremation	3 🗆 Removal fro	m State	Place of Dispo	sition (Nar	me of other place	e)		Date	20c. L	ocation - C	•	
atim.	nit. Pay artmer ortant injury e.		4 ☐ Donation 21. Signature of Fur			Was	shingt	on I	Nat.	Cein s of Facilit	ete:	ry 12, dges &	(21/ Ed	10 S Ward	uit. s F	land.Md
Ba	permit Depar Impor any in		Da	nno	e Ito	dege	39	10 5	Silv	er H	ill	Rd.,	Sui	tlan	d,M	d.20746
			23a. Part 1. Enter to shock or hear Immediate Cause (rt failure.List	r complic _iŏn_ tha only one c _use _ n	each line.	th. Do not ente	(le of dying	-1		. (rrest,	Side	1	Approximate Interval Between Onset and Death
	Medical Examiner	5 .	disease or condition resulting in death)	on	a. Due to	(or as a conseq	uence of):		<u></u>	WHI.	<u> </u>	Salla	/ •	J/03/4		1/40000
		ner	Sequentially list co if any, leading to im cause. Enter Under	nditions, nmediate	b. Pye	(of a conseq	uence of):	17	10		7	\				Monie
	ecuted and -transit	Examiner	Cause (Disease or that initiated events resulting in death) I	iinjury s	c. Lue t	o (or as a consug	uence of):	1	VD0,	rei	1 1	1320	154	2	1	Noune
8760	ificate be executed ig physician and as the burial-transit	Medical			L d	1 . 2	bec l	eve)	tic	+	Hea	nt [7.20	Ease	,	
Вох 68	ath certifi attending for use as		IF FEMALE: 23b. Was decedent in the past 12 r	months?	1 ☐ Liv	utcome of pregna e Birth 2 Feta egnant at time of	al death 3	Ectopic Other (s)		у				23d. Date		ry Day Year
	t the de by the	Physician/	1 Yes 2 9 Unknown	0	9 🗆 Un	known				I- D-+	1	1				
ls, P.	requires that the death certi been signed by the attendin should be detached for use		Part II. Other signif	Sel 1	Sons contributing to	ueath but not res	sulting in the u	ideriying	cause giv	en in Part	1.		tobacco Yes 2		1	e cause of death? pably 4 \square Unknown
ecord	e law requ has beer ge 2 shou	Completed by	by	perc	hal.	rsten	nia					24a. Was auto perf	an opsy ormed?	prid dea	or to con ath?	sy findings available inpletion of cause of
<u>8</u>	ician: The law certificate has rector, page 2:	Be Co	25. Was case referre	ed to medic	1. 18	TWI	112	•	26. Pla	ace of Dea	th (Check	1 Tes	2 🗷 N	lo 1 [Yes :	2 🛂 No
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on of	nding F ath. r: After i ie funera	icate:	27. Manner of Death 1 Natural 2 Naccident	5 Pendi		e of injury onth, Day, Year)	28b. Time of injury	M2	28c. Injury work 1 \square	rat ? Yes 2□	. [28d. Describe	how injur	ry occurred		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	I Certificate:	3 Suicide 4 Homicide	6 🗌 Could detern	ined 28e. Plac	ce of Injury - At ho ding, etc. (Specif)		et, factor	y, office			28f. Location (City or To			or Rural I	Route Number,
_	e Hospi 24 hou 9 Funer leted fillk	Medical	(Check 2	Medical I	Physician: To the Examiner: On the b	asis of examinatio	n and/or invest	igation, in	my opinio	n, death o	ccurred at	the time, date	and place	e, and due to	the cau	se(s) and manner stated.
	To the within To the comp	Δ	29b. Signature and			bus	M	23	License	number	30	9	29d. Po	ate signed (Day, Year)
			30. Name and addre	ess of person	who completed ca	use of death (Item	1 23a) (Type, P	rint) W.W	#36	00 . 1	Wan	ningh	n.D).C. 2	-001	D
	Sta Registra		31. Date filed (Monti	h, Day, Year)	32. 0 3 904 1	Registraris Signa	ture	back	L. S			0				
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		•	For State Registrar	State of Ma	aryianu / i		tificate of			F	Reg. No.	0 4150	J
,	Physici /Medio		Decedent's Name (First, Middle, La William	B. Widen	er, II	I ,				Date of Dea Month Dec	23, 20		th M
	Examin		4a. Facility Name (If not institution, gi	rner Roa			4b. City, Town, Stre	eet	-			ford	
	Funeral Director		203-30-0037	Sex 7. Ag	e (In yrs. last bi	Yrs.	Months Days		7 24 Hrs. 8. [Min. (Date of Birt Month, Da 12/2	2 /1º962	9. Birthplace (State or Fo Country) New Jerse	eigi ≥Y
	Maryland I show	ctor	Usual Residence of Decedent		10c. City, Tow	n or Loc elta						10d. Inside City Li	
	with the	al Director	10e. Street and Number 99 Griffith	Road	nad			17	314		10g. Citizen of V	What Country? USA	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 23a-f show other traumatic event, the "hodical Examiner must be rediffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			/as Decedent of Yes, specify Cu			Yes or No- an, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: White		
121	filed within 72 ho Hygiene. other than "natur ent, The Medical	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5		(Give k life. D	ent's Usual Occi ind of work doni O NOT use retir Cructic	e during mos ed)			16b. Kind of Business/Industry Construction		
Maryland 2	2 should be filed w n and Mental Hygie is marked other t raumatic event, In	To Be Co	17. Father's Name (First, Middle, Las	,	r.				er's Name (Fil		Maiden Surnan	ne)	
≥	1 and 2 sho Health and tem 27 is ma other traums		19a. Informant's Name/Relationship Eve Anne Holbr		!	•						State, Zip Code) MD 21154	
Baltimore,	permit. Pages 1 are Department of Hear Important: If Item any Injury or othe once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Conten	Removel from State	cemete	erv. crem	sition (Name of atory or other pl Y S CeI	ace) n . 1	2/28/			City or Town, State	
	bath certificate be executed Wedical attending physician and for use as the burial-transit	Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence	not enter	rkins :	ing, such a	nc.	De	ain St lta, P.	A 17314 Approximate interval Betwee Onset and Deat Mm1	
. Box 68		Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d23c. If yes, outcome	of pregnancy	h 3□	Ectopic pregna Other (specify)	ncy				ate of delivery onth Day Year	
ords, P.O.	The law requires that the de ate has been signed by the page 2 should be detached	by	9 Unknown Part II. Other significant conditions		out not resulting	in the un	derlying cause ç	jiven in Part	1.	23e. Did t	1	tribute to the cause of death	
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of \	this aldir		1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inji	ent 2 ER/C	utpatient	1 3 LI DOA		lursing Home		dence 6 Oti	_{ner (Spies)} ter 's _{red} Residence	
Division	or Attending after death. Director: After in by the funer	Certification: To	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not determined	(Month, Da	iy, Year)	Injury		∐Yes 2□]No		Street and Numi	ber or Rural Route Number,	
	ne Hospital n 24 hours a ne Funeral bletely filled	Medical C		hysician: To the best miner: On the basis of and manner st	of examination a							nanner as stated. and due to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of centifier	2			29c. Lice	nse number	9111		29d. Date signe	ed (Month, Day, Year)	

State Registrar

DHMH 17 Rev 1/2001

200, Bel Air,MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

10-09650 To

0-09650		Please Type or Print in Black I					egible.		
owanda Young		Registrar		of Health an of Death	d Menta		Reg. No. 20	110 41509	
Physicia Medical Examin	an/ ner	Decedent's Name (First, Middle,Last) Twanda Young				2. Date of De Month Decembe	ath Day Year er 14, 2010	3. Time of Death 2352 hrs	
		Facility Name (if not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Laure!	Location of	Death	4c. County o			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplated Months Davs Hours Min. Country							
		578-90-2085 1 M 2 F Usual Residence of Decedent	70	Yrs.		Oct.	8,1964	Wash.,DC	
ld how any	_	10a. State 10b. County 10c. Cit	ty, Town or Lo	cation Laurel				10d. Inside City Limits 1 X Yes 2 No	
th the Maryland	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	•	
with the		9184 Cherry Lane 11. Marital Status 12. Was Decedent Ever in	U.S. 13.	2070 Was Decedent of Hi		n? (Specify Yes or N	United	States - American Indian, Black,	
er death	Funeral	Armed Forces? Armed Forces? Yes 2 X No		If Yes, specify Cuba	n, Mexican, I	White			
nours aft	ed by	15. Decedent's Education (Specify only highest grade completed)		Yes 2 X No dent's Usual Occupa g most of working life	tion (Give ki		Specify:	Black siness/Industry	
11215-0036 Id be filed within 72 hours Aental Hygiene. aarked other than "natur eveot, the Medical Exami	mpleted	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2		Day Care	5. DO NO 1 u	se retired)	Pr	rivate	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Cor	17. Father's Name (First, Middle, Last) Elliott Gray			18.Mother's	Name (First, Middle)	
ore, MD 21215-0036 se I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-fah. ther traumatie eveot, the Medical Examiner must be notified at occo	To B	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	iling Address (Stre	et and Numb	er or Rural Route N	npson	n, State, Zip Code)	
e, MD 2 l and 2 shou Health and N item 27 is n r traumatic			Place of Dis	District	He i	t Height ghts Mc	20c. Location -	City or Town, State	
Pag Pag		1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	armony	rotherplace) Mem. P					
Balti permit. Departm Imports injury		21 Signature of Funeral Service Licensee	22	2. Name and Addres	s of Facility Lver	Hodges & Hill Rd.	Edward, Suitl	ds F.H. Land,Md.20746	
Physician //Medical		23a Part I. Enter the disease, or complications that caused the deal failure. List only one cause on each line.		er the mode of dying	, such as car	rdiac or respiratory a	rrest, shock, or hea	Approximate Interval Between Onset and Death	
kaminer		Immediate Cause (Final disease or condition resulting in death) a Cardia Arrhyt Due to (or as a consequence	of):	1 7.				Deali	
	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause		ilar Disea	ise				
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ox 68760, ant certificate be execut attending physician and or use as the burial - tra	ın/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre	egnancy 2	Fetal death 3	Ectopic	pregnancy	23d. Date of Month	delivery Day Year	
Box 68760, e death certificate be the attending physical for use as the buried for use a	Physician/Medi	1 Yes 2 No 9 Unknown 9 Unknown	death 5	Other (Specify)					
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cords, law require has been si	Completed	Diabetes Heilitus				24a. Wa	san 24b. V	Were autopsy findings available prior to completion of cause of	
ital Records, ician: The law require secrificate has been si rector, page 2 should h	Comp					 1 ✓ Yes	form <u>ed</u> ? d	death? ✓ Yes 2 No	
of Vital og Physician: After this certi	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	✓ ER/Outpati		TOthor -	Check only one) Nursing Home 5	Residence 6	Other:	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burial	-	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time	of Injury 28c. Inju	ury at Work?		e how injury occurr	ed	
Division tal or Atteodi rs after death. al Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, s			28f. Location		er or Rural Route Number, City	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowled	adae death o	courred at the time of	loto and also	or Town		an atotad	
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.		tigation, in my opinio	n, death occ				
	2	29b. Signature and title of certifier		29c. Licen	se number M.E.		29d. Date signe December	ed (Month, Day, Year) 16, 2010	
		30. Name and address of person who completed cause of death (Ite Carol Allan, MD Assistant Medical Examiner		nn Street, Baltim	ore MD	21201			
	ate	31. Date filed (Month, Day Year) 32. Registrar's Signa	ature .		IOIE, MD				
Regist	rar	JAN 0 3 2011 Beneva	1. 16	parkel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 8:55 P.M Stefano Zanello December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 ★ M 2 □ F Days Hours (Month, Day, Yea Yrs **Director** 052-68-4622 58 Aug. Italv Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14807 Poplar Hill Road 20874 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ð 1 Never Married 2 X Married filed within 72 hours after Maryland 21215-0036 1 Yes 2 K No Specify. 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Chief Financial Officer Manufacturing Company event, ti Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once, i.e. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٥ Zanello Gabriella Sforzini-Pierotti Domenico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annamaria C. Zanello/Wife 14807 Poplar Hill Rd., Darnestown, Maryland 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 12/9/2010 Metropolitan Crem. Alexandria, Virginia aure of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Rhysician/ Colonic Perforation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Non Small Cell Lung Cancer 2 Months Sequentially list conditions, Examine it any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to or as a consecuence of The law requires that the death certificate be executed the law requires that the law law is a state has been signed by the attending physician and page 2 should be detached for use as the burial-fragist resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 Live Birth 2 Fetal deal
4 Pregnant at time of death
9 Unknown in the past 12 months? Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, Brain Metastasis 1X Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death LAC ASA. Or To the Funeral Director: After this certificate has loompleted filled in by the funeral director, page 2 s. autonsy death? 1 ☐ Yes 2 ☐ No 2 K No ☐ Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital 2 🕱 No Other: 1 🗌 Yes Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 🛣 Natural 5 Pending injury 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12/8/10 D 0066990 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinni Juneja, M.D., 6420 Rockledge Drive, Bethesda, Maryland 20817 31. Date filed (Month, Day, Year) 32 Registrar's Signat

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ZUIU For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30, 201h Mary Elizabeth December 10:15 PM Abbundi Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3557 S. Leisure World Blvd. #2F Montgomery Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
Aug. 4,1957 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Min. Country) Maryland 53 Yrs Director 220-70-8600 Usual Residence of Decedent 28a-f sho 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 United States 3557 S. Leisure World Blvd. #2F 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygene. Important: If item 27 is marked other any injury or other traum. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sales - Customer Service Plant Nursery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Schrider Jerome Paul Bertha Joan Orrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeremy P. Abbundi / Son 17730 Chipping Ct., Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory: 1/3/2011 21. Signature of Funeral Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 Gist Ave., Silver Spring, MD Kothen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Metastatic Lung Cancer one month Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 X No Pregnant at time of death Month Day Year 9 Linknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 🖾 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 XNo 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: ၉ 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) XNatural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aff

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completed filled in Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Dilliams, DO D033299 January 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20016 Cynthia Williams D.O. 3720 Upton St., Washington D.C. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dec. 2010 Physician/ 29. 1:25 P M Phyllis | Miriam Azud Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Burtonsville Sanctuary at Holy Cross 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Ohio Months Days Hours Min. Month, Day Year 1923 1 □ M 2**X**XF June 87 Director 120-20-3288 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Carrol1 Westminster MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ō "natural", or items 23a o Funeral United States 21157 Apt. 149 225 Frock Dr. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes, White 3XXWidowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Keifer 2 Elizabeth Alvin LeGassie Amelia Leon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Susan Lee / Daughter 69 E. Main St., Earlville, NY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 1/3/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Rapp Funeral and Cremation Services 33 Gist Ave., Silver Spring, MD 21. Signature of Funeral Service Licensee Rapp Funeral ar 933 Gist Ave., M00582 te Sud Lok Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final ₽hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Pregnant at time of death g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated сотрые 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 00054566 12/30/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) silverspring Sunisha Bhog 9801 (rongia Arneu avilli 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:23 P ^M DECEMBER 2010 HORACE WEBER ANDERSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center @ GBMC If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1**X** M 2 □ F Months June 14 Year 1925 Washington, DC 85 579-26-0089 **Director** Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🗐 No Belcamp Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21017 1209 Magness Ct "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company 12 Insurance Agent Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary C. Fisher Horace Weber Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1209 Magness Ct., Belcamp, Maryland 21017 Gary K. Anderson / Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 and Department of Hamportant: If ite cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State any injury or Towson, Maryland Hilltop Service Corp 12-30-10 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cass, on each line. Approximate Interval Between Onset and Death of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ disease or condition resulting in death) Medical quence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown been signed by the should be detached Unknown but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to de 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has autopsy performed?

1 Yes 2 No death? l director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOLD CC 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after dean.

To the Funeral Cirector: After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certific Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 ofily one 29c. License number 29d. Date signed (Month, Day, Year) 29b. S d title 78215000 1204 ss of person who completed cause of death (Item 23a) (Type, Print) 670 oth, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Orville Physician/ John Bronson 300 A M 28,2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Med. Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 **■** M 2 □ F Days Hours Min 73 Director Apr 06 1937 Tennessee 415-56-8272 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a United States 5506 Rockleigh Dr 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? 1. Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: "natural", 3 ₩idowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Higher Education Librarian Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ permit. Page 1 and 2 should be John Orville Bronson, Sr. Jeff Elinor Sutherland 19a. Informant's Name/Relationship (Type, Print) Domestic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Richard L Spittel /Partner 5506 Rockleigh Dr. Halethorpe, MD 21227 Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ŏ 1 Durial 2 Cremation 3 Removal from State Dec 4 Donation 5 Other (Specify) Beltsville, Maryland 2010 Chesapeake Crematory Molyy 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Nautionio Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Loute Kidney Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate; 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours after To the Funeral Dire Hospital Medical Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29c. License number D0053568 Chesapeake 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 241 State Registrar

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H	Funeral Director			x 7. Age	(In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th 1 Year) 1 3	9. Birth Coun	place (State or Foreign try) PA
	aryland ia-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Baltimo	re	10c. City, Too		ation					10d. Inside City Limits 1 ☐ Yes 2 🏝 No
	with the M s 23a or 28 ust be not	Funeral Dir	10e. Street and Number 1711 Langley R	oad			10f. Zip Code 21221			10g. 0	Citizen of What Cou	ntry?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ▼Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			/as Decedent of H Yes, specify Cuba		Specify Yes or No- rto Rican, etc.)		14. Race - Americ Black, White, Specify: Wh	
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, Mary	id 2 should balth and M n 27 is mai er traumat		19a. Informant's Name/Relationship (Ty, Loretta R. Bo								or Town, State, Zip re MD 2	
Baltimore,	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place Bayv	of Dispos tery, crem 1eW	sition (Name of latory or other place Cremato	ory 12	Date 2/28/10		Location - City or To altimore	
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury	b. Due to (or as a	consequenc	e of):						
0	icate be executed physician and s the burial-transit	ledical Exa	that initiated events resulting in death) Last	Due to (or as a	consequenc	e of):						
P.O. Box 68760	death certif ie attending ed for use a	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No g Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal de		Ectopic pregnand Other (specify)	су			23d. Date of deliv	very Day Year
s, P.O.	To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	d by Phy	Part II. Other significant conditions co	ontributing to death b	ut not resultin	g in the ur	nderlying cause gi	ven in Part I.			o use contribute to t	the cause of death?
Division of Vital Records,	rsician: The law requ s certificate has been lirector, page 2 shoul	omplete							24a. Was auto perl 1 □ Yes	psy ormed?	prior to co death?	opsy findings available ompletion of cause of
tal F	cian: Tl ertifical ector, pa	Be	25. Was case referred to medical examiner?	Hospital:				lace of Death (Ch	neck only one)			N.
Š	Physion this on the direction of the dir	ျာ	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatie		Outpatien o. Time of	t 3 DOA Oth	4 L Nursing	Home 5 Res		6 Other (Specifury occurred	WHOSAICE
ono	ending eath. or: Afte the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			injury		k? Yes 2 No				
Divisi	ital or Att urs after d ral Directo led in by t		4 Homicide determined	building, etc	:. (Specify)		et, factory, office		City or To	wn, <i>St</i> a		
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	(Check 2 Modical Exami only one) 3 Certifying Nurs	sician: To the best of ner: On the basis of ease Practioner: To the	xamination and	d/or invest	igation, in my opini leath occurred at th	on, death occurre ne time, date and	ed at the time, date	and pla he caus	e(s) and manner as s	ause(s) and manner stated stated.
	N Wit	_	19b. Signature and title of dertifier	M	.D.			71287		\ 2	Date signed (Month,	Day, real)
		Ĭ	30. Name and address of person who c	completed cause of d	eath (Item 23a	a) (Type, P	St. Si	te 410	5, Bal	5ª	M. Ston	406160
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	3 1	a Kal					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month RTNICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLENBURNIE ANNEARUNDE HEALTH ANDREHAR 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F (Month, Day, Months **Dîrector** Usual Residence of Decedent show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗹 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2 1. S. A 200 DELEWARE ANE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ₩idowed 4 □ Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) TRUCKING COMPAN Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Th BOULDINST BALTIMORE, MD - 21224 BURTNICK, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12-31-10 4 ☐ Dogation 5 ☐ Other (Specify) ODENTON. 22. Name and Address of Facility DAURNERTY FUNERAL HOME M00942 2601 MOUNTAIN RD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ældiac hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death
Unknown Month Day Year signed by the a 1 ☐ Yes 3☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 1 Mknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be Hospital 2 No Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natura injury work 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) DV 30. Name and address of MD 600 Ridgely Registrar

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Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 6 46 A M ILLIAM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 №M 2 🗆 F Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. er than "natural", or iter the Medical Examiner Armed Forces ò 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 1 Yes 2 No If Yes, Give WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2005 DAUGHTER 3827 8Th ST. BROOKLYN, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Dispositjon 1 Burial 2 Cremation 3 Removal from State W. ARING CREMITTORY 4 Donation 5 Other (Specify) ODENTON, M.D. 22. Name and Address of Facility AURHERTY FUNERAL HOME Signature uporal Service License Part 1. Enter the sease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final Physician disease or condition Due to (or as a consequence of):

II TIPLE INJURIES (LUNG, SPINE) Medical resulting in death) Examiner 24 if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine 24 VEHICLE that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 2 🗌 No been signed by the sahould be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Hospital or Attending Physician; The law requires 1 🗌 Yes Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No 1 Yes 2 No this certificate **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural
2 Accident වි.ග් ම්.ග් work? 1 ☐ Yes 2 🔀 No 5 Pending motor vehicle collegion within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Investigation 032010 DEC 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, R173 City or Town, State) 2 JOHN BROWN AD LEWIS 2010 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier P2096 MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH LINGXIANG GREZNE STREET, RAITIMORZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State Registrar Han Kohr 31. Date filed (Month, Day, Year)

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ee-of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 15 FO 535 llores Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seamon Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Min Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 28a-f Yes 2 ☐ No MD è 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral Let 15-0036

Let 175-0036

Let 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 2 No ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Me Fadden randdoughter Seamon balto. 20a. Method of Disposition 200. Place of Disposition (Name of cemetery, crematory or other place Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, mo Metro Crematory 21. Signatur funeral Servite Lice 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GLICE K 293 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 ☐ Fetal dea
Pregnant at time of death Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed completed filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death Date of injury (Month, Day, Year) Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? death. Accident 2 🗆 No Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined hours after within 24 hours a

To the Funeral C Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D450 M Arthur Brooks 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner horaa Nursino If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number (In yrs. last birthday) **Funeral** 1 MM 2 □ F Months (Month, Day, Country) -9152 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland **Funeral Director** 1 Xyes 2 ☐ No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? "natural", or items 23a o 85 3308 12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical!" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Q Be permit. Page 1 and 2 should be filed or Department of Health and Mental Hyy Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date WK 20a. Method of Disposition ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signatur Funeral rvice Licensee 22. Name and Address of any in er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician, Medical Due to (or as a consequence of). Examiner to the face Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed em en Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UA Box 68760 IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Nonknown Completed within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Μ Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Wertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bothulal Scr. 106 Hulford ST. 7 504 B. Salibur ST. 7 State parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4a 23a 626 Per Phy G911 1/04/2011 IH State of Maryland Department of Health and Mental Hygiene [] | [] For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:321 Medical Name (if not institution, give street and number) or Location of Death 4c. County of Death Examiner HMORE If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 M 2 D F 7. Age (In yrs. last birthday) **Funeral** Months Country) **Director** 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City Town or Location 10d. Inside City Limits 10b. County within 72 hours after death with the Maryland **Funeral Director** Baltimore 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Walterswood 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No It Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Klac Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 7 in and Mental Hygiene.
7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) ပ 100 1 and 2 should b f Health and Mei item 27 is mark 9a, Informant's Name/Relationship (Type, Print) Howman Olster other Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory prother p permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Foneral Ser 22 Name and Address of Facility 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Laryngea Physician/ Medical resulting in death) Due to (or s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Physician/Medical Examiner Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Residence 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00054990 leted cause of death (Item 23a) (Type, Print) 901 Alameda 31. Date filed (Month, Day, Year) State JAN 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11522 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:30 PM^M Mary C. Bailey December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 1 🗆 M 2 😾 F Days Hours Min. Nov 6, 1933 Mary Tand 215-30-4111 77 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a, State 1 🗌 Yes 2 🙀 No Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a o Examiner must be Funeral 9517 Perry Hall Blvd 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. s filed within 72 hours after data Hygiene. da other than "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: white Completed 3 X Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home 10 housewife Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ဂ Angela George Gus Cotsoradis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8700 Silver Knoll Drive Perry Hall, MD 21128 Angela Jackiewicz/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Orector Signature of Eunera Service Licenses Nacie, State Anatomy Board 655 W. Baltimore Street 21201 Baltimore. MD 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate or heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final CONGOSTIVE HEART FAILURE Physician/ disease or condition resulting in death) PURC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b, Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown P.O. s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORUNARY ARTORY DISOASE Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available 24a, Was an has page 2 s autopsy performed prior to completion of cause of death? 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 TNO မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 - Natural 5 Pending 1 Yes Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

of Vital Hospital or Attending Division 24 hours after death. Funeral Director: A within 2 To the I

> State Registrar

3 📙

29b. Signature and title of certifier

CHA

only one)

NORTH CHARLES STRUOT BATIMAGE MO 21204

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] | [] For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 25, 3. Time of Death Ethel C. Bigham Physician/ Dec 12:00 P 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Future Care North Point Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. (Month, Day, Year, Country 214-16-3007 Director August. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic events. 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MDBaltimore Baltimore 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1046 Old North Point Road 21224 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2 XX Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White 3 ₩ Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William B. Romm Viola Ethel Birmingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry C. Bigham, Sr. (Son) 824 West 34th Street Balto, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans' Cemetery 1/10/11 21. Signature of Funeral Service Litenses 22. Name and Address of Facility Burgee—Henss-Seitz Funeral Home, Falls Road Balto, MD 23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Month Year ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be det ρ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? unknown autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 10 B B 26. Place of Death (Check only one) Other: 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: A simpleted filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number M.D. D 69540. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tigar. Sha 8813 Suite 204 Parkville MD 21234 balham Word 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔈 🗍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Florence Ε. Bowers P^{M} Dec. 2:26 2010 . Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 304 Hailey Avenue Brooklyn Park Anne Arundel Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Hours Min. Oct 19. 1914 **Director** 212-01-2694 96 Maryland Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Anne Arundel 1 🗆 Yes 2 🏋 No Brooklyn Park 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 304 Hailey Avenue 21225 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2√☐ No Specify Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Billing State of Maryland permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bowers John Emma Fryefogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Preston Pilcher 304 Hailey Ave., Brooklyn Park, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/30/2010 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence Examin Cause (Disease or iinjury that initiated events resulting in death) Last requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of physician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death ed by the a g Unknown signed by I be det Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy 1 Yes 2 No 1 🗌 Yes 2 N Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 🗋 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Af 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifi Month, Day, Year) 32. Registrar's Signature State 04 Registrar

DHMH 17 Rev 7/2009

Box 68760

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Division of

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dac Year BROWN 755 A 4 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Burnie ANNE C Glen WASHINGTON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 0 4 25 1924 1 🗆 M 2 💢 F 216 16 5845 86 MD **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8463 Garden Road 21122 U.S.A. filed within 72 hours after death Was Deceue... Armed Forces? Ves 2X No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 ☒ Widowed 4 ☐ Divorced Specify Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with of Health and Mental Hygien item 27 is marked other the other traumatic event, the 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fischer Maude Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8463 Garden Rd Pasadena, MD 21122 Jeannette Tamburo - daughter Department of Health Important: If item 27 any injury or other the 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗆 Removal from State 12/29/10 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem Baltimore, 21. Signature une Sevice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Day 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 4 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27 Manner Certificate: 28c, Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practiciper: To the Sest of my knowledge de 29c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar
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31. Date filed (Month, Day, Year)

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Registrar's Signature

Gobaly

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ G Medical Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death Examiner e CO 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 9. Birthplace (State or Foreign Number **Funeral** Months Days Hours Min. Maryland D97 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State Director MD 1 🔀 Yes 2 🗆 No N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21223 2018 Ramsey Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?
1 Yes 2 No Black, White, etc. Completed by 1X Never Married 2 ☐ Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hotels Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gloria Gooden Clarence M. Branham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2018 Ramsey Street, Baltimore, MD 21223 19a. Informant's Name/Relationship (Type, Print) Clarence L. Branham/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 🔲 Burial 2 🖾 Cremation 3 🗆 Removal from State Dec. 31,2010 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. Sign 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of): or Attending Physician: The law requires that the death certificate be executed as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Month Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown be detached Unknown entributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No this certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ျ 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred s after death. 1 Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide within 24 hours after To the Funeral Direc determined City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29d. Date signed (Month, Day, Year) of ce 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 4:00 P December Brunet Agnes Clare Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Dove House Westminster 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** July 12, 1920 Min. 1 🗆 M 2 🔀 F Months Davs Hours Country) Michigan 372-14-0293 90 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland notified Hampstead 1 Yes 2 No Maryland Carroll 靣 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any njury or other traumatic event, the Medical Examiner must be 1 ones. and. Funeral 21074 United States 1102 Suellen Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Never Married 2 Married Yes 2

✓ No ģ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 House Keeper Private Residence Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Bourdeau Clara Louise Bebeau Camille Fredilad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverley A. Olson/daughter 6255 Iditarod Trail Lena, Wisconsin 54139 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State final Journey Crematory 1/4/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Lig Ging Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, thomas Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ emo disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the f 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) anniverya, MD 51705

State Registrar

DHMH 17 Rev 7/2009

JAN U 4 2011

31. Date filed (Month, Day, Year)

32. Regist/jr's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR, Westminster, MD 21157, Mr. PANSURIYA 349 Mulcolm DR, Westminster, MD 21157.

01-03-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 11:50P ^M 2010 December Buffington T. John Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Chevy Chase 4601 N. Park Avenue Apt 203 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** . Year) 943 1 🛣 M 2 🗆 F Months Days Hours Sept 16, Delaware 67 216-40-9330 **Director** Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2🙀 No Maryland Chevy Chase Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number items 23a Funeral 20815 United States 4601 N. Park Avenue Apt 203 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Parole & Probation 5+ Supervisor traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Dorothy Rash 2 should be Buffington James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 sh it of Health ai : If item 27 is 4601 N. Park Avenue, Apt 203 Chevy Chase, MD 20815 Carolyn F. Buffington/wife other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of
Important: If is
any injury or c 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 1/3/2011 Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly I. Heckrotte, P.A. Clarksville, M Signature of Funeral Service Licensee canta RThomas M00957 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ vears Multiple Sclerosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? 1 Yes 2 No 24 hours after death.

Funeral Director: After this certificate I 2 **X**N Yes 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Other: 4 \(\text{Nursing Home} \) 5\(\bar{\mathbb{X}} \) Residence \(6 \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 2 🔀 No 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) iniury work?
1 \(\sum \) Yes 2 \(\sum \) No 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title

Barry Rosenbaum,

2011

31. Date filed (Month, Day, Year)

JAN 0 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29c. License numbe

D09834

3720 Farragut Avenue, 2nd floor Kensington, Maryland 20895

29d. Date signed (Month, Day, Year)

December 29, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:35 PM 2010 December William F. Brownell, Jr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Health and Rehab <u>Bethesda</u> 8. Date of Birth (Month, Day, Year) May 6, 1914 7. Age (In yrs. last birthday) If Under 1 Year If Under 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours New York Director 96 108-14-5298 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a. State Director 1 ☐ Yes 2X No Bethesda Maryland Montgomery 10f. Zip Code 10g. Citlzen of What Country? 10e. Street and Number Funeral United States 20814 10206 Fleming Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 XWidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) of the Navy Civil Engineer Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ျ Carry Reuter William F. Brownell, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10208 Fleming Avenue, Bethesda, Maryland 20814 Bette McCord/Friend 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State January cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Parklawn</u> Memorial Park 2011 Rockville, Maryland Robert A. Pumphrey Funeral Home, Chevy Chase, Ir 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signatur of Funeral Service Licensee Charten How M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Hypercholesterolemia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 x No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred XNatural 5 Pending 1 🗌 Yes 2 🗀 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, 4 \square Homicide determined 24 hours 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 To the within 2 29b. Signature and title of certi 29c. License number 29d, Date signed (Month, Day, Year) December 23, 2010 D53691

Registrar

DHMH 17 Rev 7/2009

State

Ajay Reddy, M.
31. Date filed (Month, Day, Year)

04

3200 Tower Oaks Boulevard #110, Rockville, MAryland 20852

o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 9:30PM Robert Earl Byroad December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 01ney Montgomery Montgomery General Hospita] If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** (Month, Day, Year)
[av 22. 1 1 🕅 M 2 🗆 F Months Days Hours Min. 1929 Director 579-30-2266 81 Virginia May Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f sho within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No **Brookeville** Maryland Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 20833 United States 2010 Brighton Dam Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 ☐ Never Married 2 K Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Year or Dates. 1951 - 1958 White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic
once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Chief Executive Officer Finance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earl Frank Byroad Irene Louise Woltz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2010 Brighton Dam Road, Brookeville, Maryland 20833 <u> Janet Inez Byroad/ Wife</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 28. cemetery, crematory or other place)
Montgomery
Crematorium, Inc 1 Burial 2 X Cremation 3 Removal from State 2010 4 Donation 5 Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia Physician/ deys disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 I prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ᅆ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1. X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1) 00 55694 Physician 26,2010 110001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)
JAN 0 4 2011

MATHUZ

Olyey- Ley lossulle

4000

32. Registrar's Signature

Olary, MD

20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 2:50 AM MINNIE BARABAN DE (EMACR 31 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** LEVINDALE HEBREW HOME BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🗆 M 96 Director 081-01-8681 02/04/1914 NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Director N/A MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5833 PARK HEIGHTS AVENUE, #305A 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 MEDICAL RECEPTIONIST CLERICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY SARCH ANNE ASARCH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID BARABAN/HUSBAND 5833 PARK HEIGHTS AVENUE, #305A BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ARTINGTON CEMETERY CHIZUK AMUNO 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/02/2011 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 THEMOSCI ENOTIC YEMS CARDIOVASCULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or se a consequence of) Examiner The law requires that the death certificate be executed physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 2 3 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident nin 24 hours after death the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 31, 2010 D31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 Wi BETVEDERE AV., BAZTINAE, MO 21215 BRIAN WALLACE, MI) 0. 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

U 4 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Norman Louis Corson 010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death MARFOR SELAIR Belgir Health and Prohability tien Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Min. July 8, 192 Mary land Director 212-16-9180 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Maryland 1 X Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3807 Biddison Lane 21206 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 5 ş 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 1946 3 Widowed 4 X Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working If Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Tool & Die Designer Defense Industry ulth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ Norman S. Corson Helen Amelia Georges 19a. Informant's Name/Relationship (Type, Print) (Only Child) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 it Mrs. Norma E. LaBarre-Blakely (Daughter) 6911 Century Farms Road, Felton, Pennsylvania 17322 20a. Method of Disposition Important: If its any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Bel Air, Maryland Bel Air Mem. Grands 4 ☐ Donation 5 ☐ Other (Specify) of uneral Service Licensee Jeffrey R. 22. Name and Address of Eacility
Evans Funeral Chapel & Cremation Services — Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 Testerman (M01543) 23a. Part 1 /Enterritle disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) voni Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or se a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day cate has been signed by the a page 2 should be detached to 9 Unknown OR SON, Werning Division of Vital Records, P.O. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Tes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tille of certific ൧ 22006 person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

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H DHMH 17 Rev 7/2009

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Clarence Chew 2010 2:15AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Jessup Correctional institution Jessup Arundel Ann If Under 1 Year If Under 24 Hrs. 5. Social Security Number VIII 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month,(Day, Yeat) Birthplace (State or Foreign Country) **Funeral** 12M 20 F Months Deys Hours Director <u>unk</u> MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show as 1 and 2 should be filed within 72 hours after daath with the Marylan of Health and Mentel Hyglens. Hearts 23a or 28a-1 show other treumstic event, the Medical Examiner must be nothed at 1 ☐Yes 2 ☐ No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1514 Gorsuch Funeral Ave 21218 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: Completed Decedent's Usual Occupetion
 (Give kind of work done during most of working
 life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steelworker 12th Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Chew Sr Ruth Chew-ဥ Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clrice Chew 5928 Northwood Dr Balto, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of H important: If iter eny injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/23/10 Ardent Cremation Hanover, MD 21070
22. Name and Address of Facility Phillip A Weatherford FS Pa 21. Signature of Funeral Service Licenses pu lec 2431 E. Oliver Street Balto MD 21213 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) · advanced congestive heart Jailure & conditiony opathy Examiner Due to (or as a consequence of): Physician/Medical Examiner Cardiopulmonary
Due to (or es a consequence of): arrest ettending physician and for use es the buriel-trensit certificeta ba executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Chronic Kidney disease

Due to (or as a consequence of): . History of myo cardiol infarction & arrhythmia P.O. ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Diabetes mellitus history -History of hepatic 3 Probably 14 Unknown 1 ☐ Yes 2 ☐ No been signed be should be date Records, Be Completed by encephalopathy Hepatitis Cintection 24b. Were eutopsy findings evaileble prior to completion of cause of death? 24a. Wes an autopsy performed? Hypertension this certificate hes I Gout DNR 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hyperlipidemia Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner/
Pes 2 No decline Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ To the Hospital or Attending Physi within 24 hours eftar daath. To the Funerel Director: After this completaly filled in by tha funaral dir 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 2 ☐ Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010 yours MD DO057222 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Yonas SISAY 7800 House of correction Rd, Jessup, MD

32. Regiştrer's Signeture

State

Registrar

31. Date filed (Month, Day, Year)

JAN U 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g911 1-5-11 vt. State of Maryland / Department of Health and Mental Hygiene 2 1 | 1 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thelma Mary Conway December 2010 11:03 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Gilchrist Center Baltimore Towson Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 26, 1943 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛣 F 214-40-0756 67 Baltimore, MD Director Usual Residence of Decedent "natural", or items 23a or 28a-f show incal Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me ical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Carney MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9740 Magledt Road Funeral 21234 United States 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Retail/ Elementary/Seconday (0-12) College (1-4 or 5+) Bowling Alley Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Vivian Lucille Poole George Jacob Wiederock 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll F.X. Conway 9740 Magledt Road, Carney, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of January 2011 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral 8800 Harford Chapel & Cremation Rd. Parkville, MD 2 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mm diate Cause (Final Physician tise se or condition Medical resulting in death) Due to (or a consequence of: Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Day Pregnant at time of death Month Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed?

Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? <u>|</u> 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. neck 29h 29d. Date signed (Month, Day, Year) D0071287 Name and address of person who completed cause of death (Item 23a) (Type, 21204 0 v ite 4105. ha 31. Date filed (Month, Day, Year) State IAN 0 4 201 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12-22-2010 **Physician** 12:00 P M Lucille Custis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 1300 Brushing Lane Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 06-28-1922 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Phillipines 1 ☐ M 2 💢 F 88 150-24-2639 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Harford Director Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1300 Brushing Lane 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: Filipino Completed by 3 Widowed 4 □ Divorced other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Inspector Electronics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown is marked 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:9 Department of Health at Important; If Item 27 is any injury or other traconce. 1300 Brushing Lane Bel Air, MD 21015 Jesse Malone Jr (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 12-23-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee, Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Fart1. Enter the disease, or complication, that caused the dealh. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PERCBIAL Unsular Disense **Physician** TMOS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1☐ Yes 2☐ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ('orowary Astern Disense 1 Yes 2 No 3 Probably 44 thknown Completed Renol Koilure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1∐ Yes 2☑No ospital or Attending Physiclan: hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospital 1 🗕 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D39889 Teccopser 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLEDAR SPACES 615 W. MRPHAIL BLIAN MAD 21019 BLERRA 31. Date filed (Month, Day, JAN 0 4 201 32. Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed after death. Division of Vital Records, P.O. Box 68760. : After ! Director: filled in by the To the Hospital within 24 hours a To the Funeral C

6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of of

MD D0032654

16/2010

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

21032 2033 Penderbrooke Dr. Crownsville, mD

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 Gordon E. Dailey, Jr. 8:00 A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Madonna Heritage Jarrettsville Harford 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 XM 2 □ F Months March 23, Year) 75 Hours 218-30-5061 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director or 28a-f Baltimore 1 Yes 2XX No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2709 Sarah Lane Examiner must 21234 United States "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 XMarried þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chief Engineer State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gordon E. Dailey, Sr. Mary Catherine Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Dailey - Scouse 2709 Sarah Lane, Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 Burial 2XX Cremation 3 Removal from State Evans Funeral Chapel and Crenation Services Pelair 4 ☐ Donation 5 ☐ Other (Specify) 2011 Forest Hill, Maryland 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services - Parkville
8800 Harford Road, Parkville, Maryland 21234 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ End Stepe Dementa bear Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 9.1.6 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1450 UD has autopsy perform prosio to cancer breest Hx Colon Yes 2 XNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifications and the Funeral Director, After this certification. **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) 😝 ८ 🗢 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 No eral Director, A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1731295 12/30/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wends K(6452 5701 Kenwood Ave Balhonine 21206 31. Date filed (Month,) Da 2. Registrar's Sigr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GERTRUDE 2010 FLORENCE DISNEY Month 0047 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL SHADY GROVE MONTGOMERY ROCKVICLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day Year | 927 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 - M 2 / F 212-24-6749 83 **Director** Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD GATTITORSBURG MONTGOMER 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 736 Westside Drui Funeral 20878 US 4 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2- Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 - Widowed 4 - Divorced Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) FREDERICK COUNTY Elementary/Seconday (0-12) College (1-4 or 5+) AIDE 12 74 4CAL11+ HEACTH DEPT. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM 01665 DOROTHY ROLLINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20586 STRATH-HAVENDR. GAITHERSIBURG MD 20800 ESTHER DIGGS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State RESTHAUGN MEM. CAR. DEC. 29, 2010 PRESTRUCK MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lio 22. Name and Address of Facility EARY L. ROLLING AN. HOME Pollis Houry X. 110 WEST SOUTH ST PREDERICK MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Interval Between Immediate Cause (Final atherosclerotic coronary artery Onset and Death Priysician/ disease or condition resulting in death) years Medical Due to (or as a consequence of): Examiner diabetes mellitus Leavs Sagus daily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): hypertension attending physician and for use as the burial-trans that initiated events Due to or as a consequence of): resulting in death) Last percholes terolemia Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year ed by the a detached t Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 1 No death? 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: ၉ 1 Inpatient 2 SER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖺 Natural 5 Pending Accident work? 1 ☐ Yes 2 ☐ No hours after death ineral Director; A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination arrows investigation, it my opinion, decarring Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 22,2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville, Maryland 20850 Evancich, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 0 4 201

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AM 5:30 Carmen Deschapelles Medical Sister Mary 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Future Care Baltimor Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 🗆 M 2 🖫 F Hours Director Yrs 220-60-7864 86 09 06 Cuba Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No MD Baltimore NA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 701 Gun Road 21227 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 þ 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exagonee. Black Completed 3 ☐ Widowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Teacher 4yrs+ School Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Jose T. Deschapelles Maria Cossio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 <u>Sister Mary Clarice Proctor</u> Gun Road, Baltimore, Md 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Loudon Park 1/6/2011 Baltimore, 21. Signature of Funeral Service License 22. Name and Address of Facility
March F/H West
4300 Wabash Av March F/H West
4300 Wabash Ave, Baltin
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21215 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ hypovia disease or condition resulting in death) Medical Due to (or /s a consequence of): Examiner Severe Imonar 10000 Sequentially list conditions. Examine If any, leading to immedia cause. Enter Underlying Cause (Disease or linjury use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HTN, diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Manusing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940 Bastern 31. Date filed (Month, Day, Year)

JAN 0 4 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EETON 6:09 AM 2010 2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bon Secour Hospital Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, O4 2] If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🟋 Director 73 231-44-8246 Usual Residence of Decedent 28a-f show 10a. State 10b County must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD NA Baltimore 1X Yes 2 □ No 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a 2132 Koko Lane 21216 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black. White, etc. "natural", or þ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) within 12th grade 4vrs Teacher Archdiocese Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be James DeJarnette Juanita Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harness Court Apt T-3, <u>Donna Smith-Daughter</u> Pieksville, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o ō cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 12/30/2010Baltimore, Md 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West 300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one caus an e caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Immediate Cause (Final disease or condition Onset and Death ₽nysician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran attending physician Physician/Medical that the death certificate be Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) o in the past 12 months? Month Day Year Pregnant at time of death 2 No the detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has certificate performed^a 2 No Yes 2 No 1 Yes Hospital or Attending Physician: Division of Vital the funeral director. Be 25. Was cas Place of Death (Check only one) Hospital Other 2 | No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury s after death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) Signature and title of certifie an

DHMH 17 Rev 7/2009

State

Registrar

Baltimore stress

2500 W.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Month, Day, Y

Year!

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8 2010 9:40a. Medical Douglas 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2802 Pinewood Baltimore Ave If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last hirthday) 8. Date of Birth **Funeral** (Month, Day, Days 1 - M 2 X F Director Yrs 214-16-5302 92 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1X Yes 2 □ No NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21214 2802 Pinewood Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married à Yes 2x No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 ☐ Widowed 4 ☒ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Misty Harbor Elementary/Seconday (0-12) College (1-4 or 5+) Coat Factory 3rd Grade Assembly Line na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Laura Slone Frank Gladney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5262 Glenthorne Ct., Rosedale, Md 21237</u> Magalene D. 20a. Method of Disposition Brown-Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/3/2011 Woodlawn, Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 21215 Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ CONGESTIVE HEAR disease or condition Medical resulting in death) **Examiner** CHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atter in the past 12 months?

1 Yes 2 No Day Year ☐ Pregnant at time of death ☐ Unknown 1 Yes 2 4 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MSLLIFVI 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed?

1 Yes 2 No CHRONIC FAILURS 1 Yes 2 No 25. Was case refe red to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 K Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural
Caracident
Suicide
Homicide To the nopper...
within 24 hours after death.
To the Funeral Director: Aft 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) ELLE Shot LOCH MAVEN BLVD, BALLIMORE 31. Date filed (Month State 4 U Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1234 PM Odessa Viola Dunson December 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agner Baltimose Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 TF Yrs. 219-58-6238 59 Director 10/05/1951 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 1∩a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expediment mast be requiled at 1 □Xes 2 □ No Funeral Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2216 Roslyn Ave. Apt2 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify Completed by Specify 3 X Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafe Metro Pole years Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Be ပ္ Thomas Price Irene Gant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4917 Challendon Rd. Ap Bernice Gantt (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Joseph Brown F/H
And Crematory 20a. Method of Disposition Cof P. Date 20c. Location - City or Town, State Pages 1 permit. Page Department o Important: If any Injury or once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 101/03/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr Funeral Home PA 1) Dane 2140 N. Fulton Ave., Baltimore, MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Breat Canc eau disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☑ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed Vital 1 ☐ Yes 2 ☑ No 2 🗆 No il or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DEEC Kuma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nadipell: Caton Avenue, Baltimore, MD 00 31. Date filed (Month, Day, Year)

JAN 0 4 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:50 PM orse ena ecember ZOI Medical 4a. Facility Name (if not institution, give street and number Examiner Town, or Location of Death 4c. County of Death Ba timore N/A 8. Date of Birth 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Hours 0977577946 Maryland Director 64 214-52-7674 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3033 Seamon Ave. 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces'
1 Yes 2 If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Patient Care Coor. University of MD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဍ William Thomas Gross Naomi Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi Gross(sister) Bethune Rd., Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 01/07/11 Baltimore, MD 4 Donation 5 Other (Specify) Arbutus Cem. 21. Signatury of Funeral Service Licensee ²²Jose and ddresh of Fall Frown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or cardilling) Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 ☐ Yes 2 ≡ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed^a 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2[·]₽ No Hospital Other: 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certification 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hanover ST, Baltimore, MD 3001 South MN Jeorge Ho State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year Walter Karl Doepke DEcember Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** July 25, 1934 1 📈 M 2 🗆 F Hours Min. Director 76 213-32-255 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2708 Pelham Avenue 21213 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. \$52-54 1 ☐ Yes 2 🛛 No Specify: white Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 <u>design engineer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Karl LUdwig Doepke Ruth Evelyn Rearn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy S. Doepke/spouse 2708 Pelham Avenue Baltimore, MD permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 D Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) . Sign ture of Funeral Service Licensee 22. Name and Address of Facility Board 655 W. Baltimore Street rector Raltimore MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ eno carcinona disease or condition Medical resulting in death) Due to (or as a onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No the detached g Unknown Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate Yes 2 🚺 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗓 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 🔼 Natural Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AARON 1HVUKS 01 N. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 04 Registrar

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		State of Maryland	/ Department of I	Health and M	•	9	11546		
		Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of I	Death	2. Date of Deatl	eg. No.	3. Time of Death		
Physicia Medic		Harold Raymond Dodson			Month 1 2	Day Year 29 20 /0	15:35 PM		
Examin		4a. Facility Name (if not institution, give street and number) G 00D SAMARITAN HOSPITA		r Location of Death	MD	4c. County of Death N/A			
Funeral Director		5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last 1 ☑ M 2 ☐ F 49	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, August 2	9. Birthp Count Nat	lace (State or Foreign ry) yland		
aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	own or Location Parkville			11	0d. Inside City Limits		
vith the Ma 23a or 28 st be noti	Funeral Director	10e. Street and Number 2519 Burridge Road	10f. Zip Code	234	1	10g. Citizen of What Country?			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Fune	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cubi	an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - America Black, White, e Specify: Whi	tc.		
nin 72 hour ne. ihan "natul e Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired) Contractor	during most of working	g	16b. Kind of Business Ind			
oe filed with ntal Hygier ced other t s event, th	a	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	*	ovements			
2 should k ith and Me 27 is mark traumatic		Thomas W. Dodson, Sr. 19a. Informant's Name/Relationship (Type, Print) Catherine Dodson Mother	19b. Mailing Address (Street 2519 Burridge	and Number or Rural	Route Number, (City or Town, State, Zip C	ode)		
age 1 and ent of Heal nt: If item 3 y or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ce) 1/3/20		20c. Location - City or Tov Marriottsville,	· ·			
permit. F Departm Importa any inju		21. Signature of Funeral Service Licensee	22 Name and Addre Burgee Hens 3631 Falls	ss of Facility SS-Seitz Func Road, Baltin	eral Home. Nore. Mary	, Inc. 21211			
be e siciar burit	ical Examiner	23a. Part 1. Enfer the disease, or complications that caused the death. D shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the con	SHOCK ce of): MONAS P			st,	Approximate Interval Between Onset and Death		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours are death. To the Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 🔲 Ectopic pregnanc	су		23d. Date of deliver	ry Day Year		
uires that the signed by the detail	ed by PI	Part II. Other significant conditions contributing to death but not resulting CHRONIC OBSTRUCTIVE				acco use contribute to the			
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Physician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/ 27. Manner of Death 28a. Date of injury 28i	Outpatient 3 □ DOA Oth	4 ☐ Nursing Hom	e 5 Resider	nce 6 Other (Specify)			
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ne Hospita in 24 hours ne Funeral pleted fillec	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge only one) 3 Certifying Nurse Practioner: To the best of my knowledge only one)	d/or investigation, in my opinio	on, death occurred at th	ne time, date and	d place, and due to the caus	se(s) and manner stated.		
To the withing to the complex		29b. Signature and title of certifier	29c. License	_		2d. Date signed (Month, D	ay, Year)		
		30. Name and address of person who completed cause of death (Item 23a		BLVD, H	BALTIN	NORE, MD	-21239.		
State Registra	e ir	KARUNAKAR AKASAPU, 5601 31. Date filed (Month, Day Year) 2011 (32. Registrar's Signifure	parke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ZUIU Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Barbara Ann Davis December 7:55 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Union Memorial Hospital 7. Age (In yrs. last birthday) 60 yrs If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛣 F Days Months **Director** 217-58-8201 7/8/1950 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits death with the Maryland Director Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 USA 1215 Linworth Ave Apt B1 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Jamestown College (1-4 or 5+) Elementary/Seconday (0-12) Cook Day Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Pauline MC Ceachin Willie Lee Davis Sister 19a. Informant's Name/Relationship *(Type, Print)* Wanda Ruth Crowder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 1215 Linworth Ave Apt B1 Balto MD Rutledge 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Mount Carmel Cem 1/8/2011 4 Donation 5 Other (Specify) Balto Maryland 22. Name and Address of Facility Phillip A. Weatherford FS PA 21. Signature of Funeral Service Licensee Ship susuch 2431 East Oliver ST Balto MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ademo car cinoma disease or condition) 10 moio Medical resulting in death) Due to (or * a consequence of): Examiner ta bolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and the burial-transit Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death sate has been signed by the a page 2 should be detached Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: မ 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2438946 December 27 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21218 Baltimore Fast Parkwan 201 University Hanna 31. Date filed (Month, Day, Year). State Registrar JAN 04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death . 30,20^{Year} Physician/ Carmella December Diorio 8:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glen Burnie Health & Rehabilitation Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 1 🗆 M 2 🔯 March 1, 1931 **Director** 123-22-6288 Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Anne Arundel Co. Glen Burnie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 923 Sheila Drive 21061 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Yes 2 No Yes, Give 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Hsual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 yrs. Owner Dress Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Diorio Thomas Philomena Arcomone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Cheryl E. Small / Friend 7502 Jacqwill Road Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) Entombment Glen Haven Mem. Park 1/04/2011 Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation /M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ATRIAL PAROXYS MAL TIBRILLATION Physician disease or condition resulting in death) Medical Due to (or as a consequence of):
H PERTENSION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) DIABETES MELLITUS . attending physician and for use as the burial-transl Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last YSPHAGIA Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPOTHYROIDISM 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed CHRONIC OBSTRUCTIVE PULMONARY Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? DEMENTIA Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🖾 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar DHMH 17 Rev 7/2009 only one)

29b. Signature and title of certifier

PKBonu

Bai Kanu. 3233

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUPERIOR

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Registrar's Signa

821.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

BOWIE MD

29c. License number

D0058580

29d. Date signed (Month, Day, Year)

12/30/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A^{M} Anne Doty 2010 Sue December 8:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 232 Perrywinkle Lane Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1942 Washington, D.C. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗓 F Yrs Director 578-54-8790 68 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 232 Perrywinkle Lane 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William F. Donahue, Sr. Grace Malloy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9309 Angelina Circle, Columbia, Maryland 21045 Jeff Houston / Son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 January 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 2011 Souls Cemetery Germantown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ Coronary Artery Disease disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Year Pregnant at time of death 5 Other (specify) Month Day the 1 L Yes 2 g 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed this certificate 2 No 1 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 🔀 Residence 6 🗌 Other (Specify) 1 Tyes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After # 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No Accident Investigation s after death | Director: / 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying N rractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 29c. License numbe December 29, 2010 D35370 e of death (Item 23a) (Type, Print) and address of person ho completed car 11125 M.D. Rockville Pike #104, Rockville, Maryland 20852 Backowski, An State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 11:45 Betty Jane Eves 2010 26. December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Reeders Memorial Home Boonsboro If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day,)
July 30, 5. Social Security Number 7. Age (In vrs. last birthday Year) 1922 **Funeral** Days Months 1 □ M 2 🕅 F 88 Maryland 213-18-9932 **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10h. County 10a. State 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Madical Externiner must be notified at 1 ☐ Yes 2√ No Director MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with USA 21740 17816 Red Oak Drive Funeral death v 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after on and Mental Hygiene. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 □Yes 2X No Specify: white ģ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home housewife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harriett Rachel Pugh George Auxt ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 920 Dewey Avenue Hagerstown, MD Health a tem 27 is Adair Eves/daughter permit. Pages 1 a
Department of Heat
Important: If item 27
any injury or other timore. 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation _5 ☐ Other (Specify) 21. Signat r Fi neral S rv e Licensee State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, object failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final do Premais Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Chronic obelrudio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient After this Medical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P1281 G DEC 26 2010 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 340 Hill Street, Hagerstown, Maryland 21740 301-739-7100 Vasant Datta

DHMH 17 Rev 1/2001

State Registrar 31. Date filed Morth, Day Year

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Eves,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #9 & 17 per FH G912 2/1/11 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Edwards Dorothy L. 10:17 PM December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 01ney Montgomery General Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y August 26 9. Birthplace (State or Foreign Country) **Virginia** Maryland 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. 229-28-2327 Yrs. **Director** 83 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural" any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No <u>Maryland</u> Rockville Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4077 Norbeck Square Drive 20853 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes, 2 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary/Office Manager Various Businesses Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John W. Lewis Lottie Pitman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10649 Weymouth Street #202, Bethesda, Maryland 20814 Linda S. Edwards/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2011 Silver_Spring, Maryland 21. Signature of Funeral Service Ligensee Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 101 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Arrh disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CON Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Day signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown s been signated the second the se COLONDANA 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has birector, page 2 s performed 2 4 No Yes 2 N 1 Yes 25. Was case referred to medical examiner? funeral director, B 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ျ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) December 30,2010 52481 M- 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Davie Plotria SILI Prince Philip 5/11/0304 Mus. DVIVE Olney 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JAN 0 4** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 06-2010 Physician/ Christena Edwards 11:00pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Thomas More Nurs. Rehab Cntr Prince George's Hyattsville . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) 2 - 17 - 191 1 ☐ M 2 ☐ X Davs Min 92 **Director** 578-42-3150 Usual Residence of Decedent 10a. State should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Prince George's 1 X Yes 2 No Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4922 LaSalle Road 20782 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 ☐ Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) nurse's Private Industry 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental H David Edwards Connie Vine Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $214\ 20$ th $ST\ NE\ #2\ Washington, DC 20002$ Virginia Edwards/sister Page 1 and 2 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ₽ **= ₽** 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or Lincoln Mem. Ceme :12-11-2010 Suitland, MD Signature of Superal Service Licenses 22. Name and Address of Facility Cedar Hill FH,4111 PA Ave., Suitland, MD a. Part 1. Deter the disease, or complications the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List this one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ ARTENIOSCHEVOTIC CANDIOVASCULAN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death g Unknown Month Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tyes Other: 2 N No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month,

Day, Year)

ne and address of berson who completed cause of death (Item 23a) (Type, Print)

-MI)

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 7:40 P John E. Fo1k 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yo Oct. 29 Social Security Number 9. Birthplace (State or Foreign **Funeral** Washington D.C 1 X M 2 □ F Months Days Hours Min 577-30-0045 85 **Director** Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ıral", or items 23a oı Examiner must be ı with 1 Funeral 5701 Granby Rd. 20855 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 þ 2 🗌 No 1 ☐ Yes 2 K No Specify. White rr Yes, Give Year or Dates. W.W. II Specify: "natural", 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Research Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fo1k Edward Riner Ruth Head 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 1000 Gelston Circle, McLean, VA Armand Scala / Executor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XXCremation 3 Removal from State Chesapeake Crematory 12/31/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 21. Signature of Funeral Service Licensee MO0382 tole Dollaman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ BILATERAL PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of Examiner DAYS MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? fo Month Year Day 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown hed s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by I Records, THROMBOCYTOPENIA 1 Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an GASTROINTESTINAL BLEED page 2 autopsy death? perform the Hospital or Attending Physician: The I in 24 hours after death.
The Funeral Director: After this certificate hapleted filled in by the funeral director, page PULMONARY HYPER TENSION 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2010

DECEMBER

EDWARD

State Registrar

Medical

29a. Certifier

29b. Signatu

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only one

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e and the of certifie

m d cause of death (Item 23a) (Type, Print 30. Name and address of person who comp MEDICAL CENTER DRIVE ROCKVILLE MD 9901 SMITH 32. Registrar's Signature

DHMH 17 Rev 7/2009

within 2

To the I

backs

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0064413

29d. Date signed (Month, Day, Year)

DECEMBER

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3. 25 P M Physician/ Year Geneva Helena Fadeley December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death itizens Nursina Home Haure De Grare Hartord 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🗶 F Months Days Hours Min. April 4, 1921 Maryland 89 Director 214-16-2993 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Harford Havre De Grace Maryland 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be by Funeral 21078 **USA** 708 Lewis Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 🏋☐ No Specify: 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant American Red Cross To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stacia Hvde Thomas Mowbray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Lewis Street Havre De Grace, Maryland 21078 Beverly M. Bennington, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/31/10 Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Thomas Gregor Pame and Address of Facility Of Maryland, Inc. 29 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b Was decedent pregnant 23d Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 📈 No 욘 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural Accider injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The detail a statement of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar filed (Month, Day, Year)

Fadel

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frank Carroll Fox 2010 Dec. 2:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oakcrest Village Baltimore Parkville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Maryland Months Hours Min. Jan. 29,1926 219-18-8262 84 Director Yrs. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 ☐ Yes 2 🎇 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Walther Blvd. #2404 21234 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1944—
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Air Force Military permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Joseph Fox Lilly Jackson Parson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blvd. #2404, Parkville, MD 21234 Audrey Fox Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XI Cremation 3 Removal from State Metro Crematory Inc 12/30/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facilit Cremation Society of Maryland any in once. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Outside Disease 299 Frederick Rd., Baltimore, Maryland 21228 Onset and Death Physician Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner Due to (or as a consequence or). cause. Enter Underlying Cause (Disease or linjury the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vascular Pementia Records, 1 Yes a No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 🗌 No 1 Yes Hospital or Attending Physician: 24 hours after death. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 \(\sum \) Yes 2 \(\sum \) No Vital Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 12/30/2010 R171944 leted cause of death (Item 23a) (Type, Print) 6+1 v schealle G. Harrison NP 8800 Walther Blvd, Parkville, MD 2/234 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 555 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:00 AM December 2010 Lisle Fleming Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Abingdon Harford 4025 Abinrox Drive . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1**x** M 2 □ F Months Days Hours Country) 83 198-20-3378 Director Pennsylvania Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director Md. Harford Abingdon 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 4025 Abinrox Drive 21009 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates. 1944-1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel 8th Stee<u>lworker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ injury or other traumatic <u>Mary E. Hines</u> t. Page 1 and 2 should be thent of Health and Mer trant: If item 27 is mark Charles F. Fleming 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3423 Tames Run Road Aberdeen, Md. 21001 19a. Informant's Name/Relationship (Type, Print) 3423 James Run Road DTR Cindy Sayers permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-30-2010 |Parkville, Md_ Parkwood 22. Name and Address of Facility Schimunek Funeral, 9705 Belair Road Nottingham, Md, 21. Signat of Funeral Service License 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Physician/ mmediate disease or condition Medical resulting in death) Due to (or s a consequence of): Examiner 21 years arter OFUNATY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atte page 2 should be detached for Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by hyperlipidemia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? hypertension 24a, Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Nesidence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

larshellmo

29c. License number

D0035363

Medical Center 10 N. Greene St.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FROSCH 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD VANTAGE HOUSE COLUMBIA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1□M 2X F 99 12/24/1911 064-03-8058 NY Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 27 No Directo MD HOWARD COLUMBIA 10e. Street and Number 10g. Citizen of What Country? 5400 VANTAGE POINT ROAD 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry mit. Pages 1 and 2 should be filed within bepartment of Health and Mental Hygiene. Important: If firen 27 Is marked other than "ne any injury or other traumatic exercises." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GODSICK 2 GERTRUDE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2529 COUNTRYSIDE DRIVE, SILVER SPRING, MD 20905 JILL LEWIS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 Burial 2 □ Cremation 3 □ Removal from State BETH MOSES CEMETERY 01/02/2011 4 ☐ Donation 5 ☐ Other (Specify) PINELAWN, NY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ON GESTIVE disease or condition resulting in death) Due to (or as a consequence of): Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine EMEN Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performe 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification:

death certificate be executed attending physician and for use as the burial-trar Box 68760. ast use P.O. | signed by the a d be detached f Division or Vital Records, peen has page certificate or Attending Physician:

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shov Ex-miner must be notified at

"natural", or

Physician

Examiner

/Medical

event, the Medical

within 72 hours after death

timore, Maryland 21215-0036

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1	27. Manner of Death	
ı	1 Natural	5 Pending investigation
ı	2 Accident	_
ı	3 Suicide	6 ☐ Could not b
١	4 Homicide	determined

(Check only one)

1 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

Q. Nar	me and	address	of person	who d	completed	cause	of death	(Item 23a)	(Type,	Prin
36	0.	AR	no:	RI	1 1	12,	SI	ITE	3	9

GEH, MD 2/201.

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature back

within 24 hours after death

To the Funeral Director:
Completely filled in by the f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 23 2010 Month Physician/ Rayne Juliana Conzales 02:35 PM ECEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER 10WSON Social Security Number If Under 24 Hrs. If Under Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Year 8. Date of Birth (Month, Day, **Funeral** Days 1 🗆 M 2 🔀 F Min. Director N/A 10 23, 2010 Dec Maryland Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Harford Bel Air 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1123 Royston Place Apt. F 21015 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Portuguese Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) N/A College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Gonzales Brandy Leeper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Brandy Leeper / Mother 1123 Royston Place Apt F. Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. 30 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel 4 Donation 5 Other (Specify) 2010 Forest Hill Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Evans Funeral Chapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PREMATURIT EXTREME disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Due to (or as a consequence of): Exami certificate be executed that initiated events resulting in death) Last and trar Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 **X** No Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA in 24 hours after death.

the Funeral Director. After thi
pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of gertifi 29d. Date signed (Month. Day, Year) DO036836 127 south auto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 NELSON DAYIDSON OSLER DRIVE M.D. 7601 TOWSON MARYLAND

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Day, Year)

Registrar's Signatur

ARCEPS.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Albert Alvy Gajdosik 22:40p December 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7805 Stafford Hill Court Glen Burnie Anne Arundel Co. 8. Date of Birth (Month, Day, Year, 5/07/1922 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Country) est Virginia 1 **X** M 2 □ F Hours Director 216-14-3161 88 West Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 Funeral 7805 Stafford Hill Court United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Outside Maintenance Airport 8 vrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Gajdosik Louise Sandrik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7805 Stafford Hill Court Mrs. Debbie Miller / Daughter Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🎗 Other (Specify) Entombmen 1/5/2011 Loudon Park Cem. Baltimore, MD 22. Name and Address of Facility Singleton Funeral & Cremation M01121 SW Glen Burnie, MD 21061 Services PA; 2nd Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each in. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of,. Exami eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate bewirthin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes $5 \square$ Pending Natural 2 🗆 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certificiang Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed ompleted cause of death (Item 23a) (Type, Print) istrar's Signature 32. Reg 31. Date filed (Month, Day, Year, State Registrar

completed

(Check

State
Registrar

DHMH 17 Rev 1/2001

BUSINESS CENTER DRIVE REISTERSTOWN, MD 21136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

210

32. Registrar's Signature

UMA

JAN 0 4

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ELSA GUTBROD 11:34 AM 2 26 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** MERCY MEDICAL CENTER BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 □ M 2 🗹 F Months Days Hours Min. Germany Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical France. 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 √Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 524 N Charles Street Apt 504 21202 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otto Schelling Rosa Hartminy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Helen Driscoll - niece</u> 309 Willrich Circle Unit_H, Forrest Hill MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4D Donation 5 Dother (Specify)

21. Signature of Fund al Service Line Atlantic Crematory 12/29/2010 Glen Burnie Maryland 22) Name and Address of Facility Ambrose Funeral Home Inc 1328 Sulphur Spring Road Arbutus Maryland 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HYPOXEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DAYS PNEUMONIA ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed DAYS STROKE attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a d be detached for ☐Yes 2XNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) MD, PhD, RESIDENT 1265757728 12,26,2010

Registrar
DHMH 17 Rev 1/2001

State

, MERCY MEDICAL CENTER, 345 ST. PAUL PLACE, BALTIMORE, MD 21202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SEEBURG

DANIEL SEI
31. Date filed (Month, Day, Year)

10-09977 Mark A. Gomleck Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

C.	2	U	Section 2 to 1	0	4		5	6	1

		For State			Certifi	cate o	ע זו	reath			F	eg. No	0.		
Physician/ Medical Examine	1	. Decedent's Name (First, Middle		hony Gob	leck					2	2. Date of Dea Month Decembe	p Day r 26,			3. Time of Death 0324 hrs
	4	a. Facility Name (if not institution 4608Coachway Dr	n, give s	treet and number)				City, Town, or L Rockville	ocation of	Death		- 1	tc. County of Montgom		
Funeral Director	5	. Social Security Number 181–16–5989	6. Sex	7. Age	(In yrs. last b	oirthday) Yr	Ī	Months Days	If Under Hours	Min.	8. Date of B Septemb		1	Foreigi	nplace (State or Pennsylvania Intry)
	τ	Jsual Residence of Decedent													
and show any ace.		Oa. State 10b. County Iaryland Mont	gome	ry	10c. City, Tov	vn or Loca	ation	Roc	kvi1	1e					10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28s-f sh tified at one Director	1	0e. Street and Number					10	Of, Zip Code	20852				itizen of Wha		
ith th		4608 Coa	4000 Coachway Blive											can Indian, Black,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 13a or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		1 Never Married 2 Married	orced If	Yes, Give Year	□ No JTT			specify Cuban,		Puerto R	Rican, etc.)		White,		lte
nurs aft	٠,	15. Decedent's Education (Spe-						Usual Occupation				16b	Kind of Bus	iness/li	ndustry
5-0036 ed within 72 hours itygiene. other than "natu the Medical Exan Completed		Elementary/Secondary (0-12)		College (1-4 or 5	i+)	auring i	most	-		ase retire	ru)				Defense
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filed of the true		17. Father's Name (First, Middle,		Cobo	•				o.iviotner)omeni			ton	e
21215-0036 total be filed within 7 d Mental Hygiene. Is marked other than the event, the Medica To Be Comple		G 19a. Informant's Name/Relations		eppe Gobe	.o	19b. Maili	ng Ad	ddress (Street	and Num						
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Baltimore, permit. Pages I as Department of He Important: If ite injury or other tr	1	21. Signature of Funeral Service	Ligense	e	1	2 <u>2</u> .	Nam	ert A.	of Facility Pump i	irey	Funer	al	Home/R	ock	ville, Inc.
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Division of Vital Records, P.O. Box 687 To the Bospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the complete of the complete of the Diversities of the Control of the Diversities of the Control of the Contro	Medical C	29a. Certifier 1 Certifying F	aminer:	n: To the best of m On the basis of exa	y knowledge, mination and/	death oco	curre gation	d at the time, da	ite and pla , death oc	ace, and curred at	due to the ca t the time, da	use(s) te and	and manner place, and d	as stat ue to th	ted. ne cause(s)
To the within To the comple	₩ ₩	29b. Signature and title of certific		and manner stated.				29c. Licens	e number			29	d. Date signe	ed (Mo	onth, Day, Year)
		Mayarte D	ha!	Shell				O.C.I	M.E.			D	ecember	26, 2	010
VI	ŀ	30. Name and address of person								216.					
) 1		Margarita Korell MD.		istant Medical			Per	nn Street, B	altimore	e, MD 2	21201				
Sta Registr	***	31. Date filed (Month, Day, Year,	6	32. Registr	ir's Signature	Kel									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Decembe Physician/ **GLADYS** Ε. GALLOWAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** acIf Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year) 1924 SEPT 14 1 □ M 2 **XX** Months Hours Min. MARYLAND 86 Director 218-22-0755 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 ☐ Yes 2 X No STREET MARYLAND HARFORD CO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Page 1 and 2 should be filed within 72 hours after death with innert of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a 3017 BLUEHOUSE RD. 21154 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces? 1 ☐ Yes 2 ☐ No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: BLACK If Yes, Give 3 XWidowed 4 □ Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PERRY POINT LAUNDRY 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rosa E. Presbarry Collins John F. Collins 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md., <u> Alice Starks/Sister</u> Blue House Rd., Street, other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 🛛 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Berkley Cemetery 01-05-2011 DARLINGTON, MARYLAND 21. Signature of WILTEAM COMM FUNERAL HOME-HARFORD, P.A. Mallen 321 S PHILA. BLVD, ABERDEEN, MD 21001 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director. After this certificate has been signed by the attending physicis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Vear Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 Yes 2 No Vital 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ranas 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar JAN 04

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	_	For State Registrar	(1 t t t 1 4)	State o	ıt Marylar	nd / Depa <i>Cer</i>		e of De			F	Reg. No	ZUI	0 4	1564
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Funeral Director		5. Social Security Number 214–30–5677		м 2 [Х F	7. Age (In yrs.		If Unde Months		f Under 24 F Hours M		Date of Birth (Month, Pay,		9. E We	Sirthplace (S Country) ST Vi	tate or Foreign rginia
Aaryland 8a-f show tified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. Con MD Ba		re	10c. Ci	ty, Town or Loc Parkv									ide City Limits
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmoortant: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1908 Wildwood 11. Marital Status 1 Never Married 2 3 Wildowed 4 Divo	12 Married		2 X No	l l	Vas Dece		anic Origin? Mexican, Pu			- 1	USA 14. Race - An Black, Wh Specify:		an,
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the fune	Medical	(Check 2 ☐ Medic only one) 3 ☐ Certif	cal Examine ying Nurse I	r! On the haci	e of evamination	rledge, death on and/or invest	antion in	my opinion	doath accurr	and at the	timo data an	nd place	and due to th	e cause(s) ar as stated.	nd manner stated.
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121		30 Name and address of periods	151	pleted caus	e of death (Ite	n 23a) (Type, P	ONA	tapes	Pel.	(ockey	450	Me	Mel.	2130
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29^{Day} Month 2 0°1 0 6:35A M Yul De Hawks Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Gilcrest Hospice 5. Social Security Number 4 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 Months Days Hours Min 027247 1958 OKTAhoma 52 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland Medical Examiner must be notified at 10c. City, Town or Location Director 1 XYes 2 No Baltimore MD N/A 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21218 U.S.A. 1608 Montpelier St. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. jo, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Il Hygiene. Roofer self Employed year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or ဂ္ Page 1 and 2 should be Lola Trezzevant Perry Hawks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Perry Hawks(father) 1608 Montpelier St., Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Joseph Brown F/H And Crematory 12/31/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Manual Home PA N. Fulton Ave., Baltimore, MD 21217 3a/ Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Ph_sician/ metastutic colon concer disease or condition £ 6665 resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that initiated events requires that the death certificate be exect resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death ed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Deep vein thrombosis, reirrent 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an bleid page 2 performed? Yes 2 X No 2 🗌 No 1 Yes Hospital or Attending Physician: Be (**Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 YOther (Specify) #5 Sync + this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X/Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. after death. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12/20110 DO070635 NUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Svite 4105 Bullmore, MD 21202 Patel ~ Chewies St 6700 aura 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28^{Day} 2010^{Year} Physician/ George Rupert Hartmann 7:40 P M Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** (Month, Day,) **½** M 2 □ F Months Days Hours Min. Country) 94 **Director** 098-14-5030 Oct Ĩ916 Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 300 International Circle 21030 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white 3 ☑ Widowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Prosthetist/Orthotist NY University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Margaret Herlbauer George John Hartmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor M. Hartmann/daughter 525 Rossiter Ave., Balto., MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nassau Knolls Cem. 1/4/11 Port Washington, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Bryan W Chaty 23a. Part 1. Enter the disease, or compilitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart folium. List only one cause on each line. Immediate Cause — al disease or condition resulting in death) Onset and Death Physician/ END STAGE DEMENTIA Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Contriving Nurse Fractioner To the basis of my included a cert occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 2010

State
Registrar

DHMH 17 Rev 7/2009

2010

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 0 4 20

0-10045 lichael Martin	المما	th Please Type or Print in Black Indelible State of Maryland / Department of			ble.2010	1567
iichael warun	пеа	1- For State Certificate C			No	
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)		Reg. 2. Date of Death		3. Time of Death
ledical Exam		Michael Martin Heath		Month December 2	Pay Year 28, 2010	1020 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	ath	4c. County of Death	
		5420 Ballenger Creek Pike	Frederick	Una To Data of Birth	Frederick	halasa (Otata as
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Min.	(MM/DD/YYYY) 9. Bird Foreig	n
Billottol		220-17-5634 1 M 2 F 29 Y	rs.	Aug 3,	1981 Wa	shington.DC
wany		10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits
A . A	_	Maryland Frederick Fred	erick			1 Yes 2 X No
Maryland 28a-f show	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cour	itry?
15-0036 filed within 72 hours after death with the Maryland I Hygiene. 4 other than "natural", or items 23a or 28a-f sho i, the Medical Examiner must be notified at once.		5459 Lyndale Way	21703		United St	ates
th with	Funeral		Vas Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue		 Race - Ameri White, etc. 	can Indian, Black,
er deal	Fur	1 Yes 2 X No	Yes 2K No specify:		Specify:	r.Tladden
5-0036 led within 72 hours afte tygiene. other than "natural",	d by	or Dates:	ent's Usual Occupation (Give kind	of work done	6b. Kind of Business/I	White
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica				me (First, Middle, Mai		
212' 212' wild be a Mental marke	To Be	Joseph Albert Heath 19a, Informant's Name/Relationship (Type, Print) 19b, Maili	Maria ng Address (Street and Number			Zip Code)
MD 1 12 shou th and 1 27 is rumatic	_		Box 606 Hedges			
		20a. Method of Disposition 20b. Place of Disposition	osition (Name of cemetery,		20c. Location - City or	
Baltimore, permit. Pages I as Department of Hee Important: If ite injury or other tr			ney Crematory 1	1/4/2011	Woodbine,	Marvland
altir mit. I partme portm ury on	ΙW		Name and Address of Facility 1ng Home Cremati			-
ELGE O		Mullinata K Thomas M00957 pe	verly L. Heckrot	tte, P.A. (Clarksvill	e, MD 21029
Physician /Medical		23al art I. Enter the disease, or complications that caused the death. Do not enter liure. List only one cause on each line.	the mode of dying, such as cardia	c or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. <u>nxvcodone intoxicati</u> Due to (or as a consequence of):	lon			Death
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	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
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ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be redeath. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the buril by the funeral director, page 2 should be detached for use as the buril	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
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Division of Vital Records, real or Attending Physician: The law requints after clean. **al Director** After this certificate has been select in by the funeral director, page 2 should 1	B B	25. Was case referred to medical examiner?	26.Place of Death (Che	<u> </u>		
of VIII Physic er this eral dir	욘	1 Ves 2 No Pospital 1 Inpatient 2 ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time of	" o box	28d. Describe hov	esidence 6 🗹 Other	Scene
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risic r Atte er dea irector	licat	2 Accident Investigation 3 Sucide Suicide Could not be 28e. Place of Injury - At home, farm, str		28f. Location (Stre	eet and Number or Ru	ral Route Number, City,
Divi	Certification:	4 Homicide determined (Specify) found in wood	ds	Pike Fr	ederick, M	enger Creék D
Divi the Hospital or hin 24 hours afte the Funeral Dir		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner; On the basis of examination and/or investig and manner stated.				
	2	29b. Signature and title of certifier	29c. License number		9d. Date signed <i>(Mor</i>	
		Card Hillan	O.C.M.E.	,	December 30, 20	,10
Loud		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Ba	Itimore Street. Baltimore.	MD 21223		
-	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
S Regis		IAM U A OOSS A				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a&b PerINF G911 1/10/2011 IH State of Maryland / Department of Health and Mental Hygiene [] for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a 812 Wicklow Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 🗆 M 2 💢 🗏 239-24-9903 Director 88 Feb. 6, 192 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director 1 Yes 2 No Baltimore MD n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 812 USA Wicklow Rd 21229 within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 😾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Wildowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>unknown</u> Housekeeper home Be permit. Page 1 and 2 should be filed be be partment of Health and Mental Hyg Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည P.P.Paul Sallie Barr 19a. Annie Neme/Relationship Type Printee) 191 7009 Farming ton Rose Rocky Mount, N.C. 27801 5207 Hillburn Ave. Baltimore Md 2120 Hughes/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State injury 4 Donation 5 Other (Specify) pnForestVetCemJanll ,2dllOwingsMills,MD The of Funer Service Licenson any CALVIN B. SCRUGGS FUNERAL HOME Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician a the for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA o 24 hours after death.

E Funeral Director: After this contend filled in by the funeral directed filled fill 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Yes 2 No Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the ! Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print 2. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Year}010 Physician/ December 9:05pM <u>Vergie Edella</u> Hubble Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Aberdeen Harford <u>3134 James Run Road</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** Days Hours Min. 1 ☐ M 2XXF Months 09/21/1918 Virginia Director 92 235-36-9306 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes XX No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 **USA** 3134 James Run Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Ves 2 No 1942—
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: Completed 3√Widowed 4 □ Divorced Year or Dates. 1944 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) in home 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Coen Wright Tda Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda L. Hubble (daughter) 3134 James Run Rd.. Aberdeen, MD 21001 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/3/2011 BelAir, Maryland Oak Grove Cemetery 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition congestive heart Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner 10 years Non-Ischemic Cardiomnopatho Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and after use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year should be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypothypoidism 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an NIDDM has autopsy filled in by the funeral director, page 2 performed 1 🗆 Yes 2 🗆 No 1 Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 🗷 😽 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ျ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No . Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Lessertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier 12/31/10 20048050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #400 Aberdeen MD 21001 15 Parke St. Shukla 5. Prashant 31. Date filed (Month, State Registrar

ORIGINAL

			Please amend #19 1_For amend #2	e Type or Print in b Per FH G911 20b Per FH G911	Black Indeli 1/04/2011 10/1/10/2011	ble Ink. Ensu Jh Int of Health a	re All Co nd Menta	pies Ar I Hygien	e Legible	. 41570
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-	Examin	er	Maryland Gol	ncal HOSP	al R	ty, Town, or Location of	City	- '	tc. County of Dea	tn
	Funeral Director		5. Social Security Number 216-59-3/76 Usual Residence of Decedent	Sex 7. Age (In yrs. 1 ☐ M 2 🕦	last birthday) If Und Month	der 1 Year If Under 24 s Days Hours	4 Hrs. 8. Date Min. (Mo	of Birth oth, pay Year 6/22	1926 9. Bi	thplace (State or Foreign ountry)
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	vith the M 23a or 28 Ist be not	eral Dir	10e. Street and Number	gton Avenu		Zip Code 2/2/7		10g. (Citizen of What C	ountry?
e76	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates.	.S. 13. Was Dec	edent of Hispanic Origin ecify Cuban, Mexican, 2 XNo Specify:	n? (Specify Yes Puerto Rican, et	or No-	14. Race - Ame Black, White Specify:	
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I'me (and 2 should be filed Health and Mental Hy tem 27 is marked oth tther traumatic event		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addre	ess (Street and Number	or Rural Rous	ant gra	de// dy TovColline De///e///	etetut 06 903
\mathcal{LeR} altimore,	. Page 1 and ment of Heal tant: If item ; jury or other		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	Place of Disposition (N cemetery, crematory of Lenmount	ame of rether place 1	/06/201	$\frac{1}{20c}$	Location - City o	Maryland
Balt	permit. Page Department Important: any injury o		21. Signature of Funer LiService Licer	10/553	22. Name	and Address of Facility	F.S. &	Raffix	york Ky	1.2/2/2
	Pnysician/		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the dea	ath. Do not enterwhe mic	ode of dying, such as ca	ardiac or respira	tory arrest,	9,00	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Dy to (or as a cons	ruence of):	/				
	ed	Examiner	E aquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consec	quence of):					
0	be executed sician and burial-transit	_	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🔲 Ectopi	c pregnancy (specify)			23d. Date of de Month	elivery Day Year
ls, P.O	uires that th signed by Id be detad	d by Pł	Part H Other significant conditions	contributing to death but not re	sulting in the underlyin	g cause given in Part I.	236			o the cause of death?
Record	he law requ te has beer age 2 shou	omplete						a. Was an autopsy performed?	prior to	utopsy findings available completion of cause of
tal	ctor, p		25. Was case referred to medical examiner?			26. Place of Death			NO TO TE	S 2 1 1 1 0
fVii	Physic this or	욘	1 ☐ Yes 2 ☑ No 27. Man of Death		ER/Outpatient 3 28b Time of	T		Residence	6 Other (Spe	cify)
27. Man of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of injury at work? 28c. Injury at work? 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										ıral Route Number,
Divis	pital or A		4 ☐ Homicide determined	building, etc. (Special special specia	fy)		City	or Town, Sta	te)	
	ne Hos in 24 hd ne Fun pleted	Medical	(Check 2 L Medical Exar	niner: On the basis of examinations or see Practioner: To the best of n	on and/or investigation,	in my opinion, death occi	urred at the time	, date and pla	ce, and due to the	cause(s) and manner stated.
	To t with To tl	_	29b. Signature and title of conffier	0	2	9c. License number 89632		29d. [Date signed (Mont	h, Day, Year)
ik			30. Name and address of person who	completed cause of death (Iter	m 23a) (Type Print)	's mare	yland	Git	eneral	Hospital
	Stat Registra	.0	31. Date filed (Month, Day, Year) JAN 0 4 20	2. Registrar's Signa	gre faces	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30 Day Physician/ Month Earl R. Jackson, Jr. 2010 9:05 A M Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Perry Hall 9106 Sandra Park Rd. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) 1 X M 2 - F Months Hours 85 Director 1925 Dec. 219-10-4962 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Perry Hall MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21128 9106 Sandra Park Rd. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?

1 👿 Yes 2 🗆 No Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 ☐ No Specify: white Specify Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Military Navy Officer n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٩ Ruth Wehner permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is mark any injury or other traumatic Earl R. Jackson, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9106 Sandra Park Rd., Perry Hall, MD 21128 Janice C. Jackson/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/4/Page 1 🌠 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD Signature of Funeral Service L 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney
10 W. Padonia Rd., Timonium, MD Inc. 23a. Part 1. Enter the disease, or complication shock, or hear failure. List only one complications are complicated as the complete state. ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Immediate dause (Final Onset and Death Physician/ disease or con resulting in de Medical Due to (or as a consequence of): Examiner MONTV Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗀 Yes No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dil 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 059354 3 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4924 Campbell Blvd., Ste. 200, Balto., MD 21236 Raymond Zollinger, M.D. 31. Date filed (Mo A Day, Jean 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Month Year Doris E. Johnson 29 Dec. 3:28 Α 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. Feb. 14 1 🗆 M 2 💢 F 81 149-22-2335 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Timonium 1 Yes 2 X No Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 119 Hollow Brook Rd. 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 🗓 No Specify: white Specify: 3 X Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Macko Michael Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7847 Midday Lane, Alexandria, VA 22306 Robin Ann Johnson/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/3/1^P1^{te} Dulaney Valley Memorial Gardens Timonium, MD ☐ Donation 5 ☐ Other (Specify) 21. Si turd Funeral Servic I ensee 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 Bry an We 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List inly one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final metastatic disease or condition resulting in death) Colon Cancer Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23d. Date of delivery 3 Ectopic pregnancy etal death 5 Other (specify) Month Day Year of death

Physiciani Medical Examiner

ending physician and use as the burial-transit

been signed by the attending physician should be detached for use as the burial

should

nours after death.

neral Director: After the filled in by the funera

Department of Important: If it any Injury or o

Physician/

Medical

10a. State

MD

Director

Funeral

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Completed

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Examiner

Funeral

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

and Mental Hygiene.

t. Page 1 and 2 should be treent of Health and Me tant: If item 27 is mark

the

traumatic event,

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Completed by Physician/Medical To Be Certificate:

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been sinned by the manner.

Division of Vital Records, P.O. Box 68760

IF FEMALE; 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live Birth 2 For time of pregnant at time of
1 Yes 2 No	9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Drabetes, covering when discuse

23e. Did tobacco us	se contribute to the cause of death?
1 🗆 Yes 2 🕻	XNo 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed?.	24b. Were autopsy findings available prior to completion of cause of death?

	25. Was case referred to medical
i	examiner?
4	1 ☐ Yes 2 ☐ No
Ì	27. Manner of Death
ı	1 Natural 5 Pendi

2 Accident

	1 LI Inpatient 2
	28a. Date of injury (Month, Day, Year)
n	

Hospital:

2 🗆	ER/Outpatient	3 🗆 1	DOA	Other:		
ar)	28b. Time of injury	М	28c.	Injury at work? 1 Yes		
At home, farm, street, factory, office						

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

	1 Yes 2	No 1 Yes	2 No
of Death (Check on	ly one)		
4 Nursing Home	5 Residence	6 Other (Specifi	y Hospice

3 ☐ Suicide 4 ☐ Homicide		6 Could not be determined
29a. Certifier	1	Certifying Physi

ı		IVI		, _	
ĺ	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	facto	ry,	office	

1
28f. Location (Street and Number or Rural Route Number City or Town, State)

28d. Describe how injury occurred

only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day,
> Son BELL MID	06070635	12129110

Investigation

290.	Licerise	IUIIID	eı		
0	600	01	0	3	<

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only

2 🗌 No

Baltmore

zsu.	Date	signed	(IVIOIII	111,	Day,	(car)
3	21	79	11	1		

30. Name and address of person who	o com	pleted cau	se of dea	ath (Item 23a) (Type, Print)
Leura Patal	6	701	N	C	hantes
31. Date filed (Month, Day, Year)		- PE-	Registrar'	s Si	ona ture -

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b Per FH G911 1/13/2011 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Day 9, 2010 Physician/ Juchno 3:25 AM Edwin Α. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Jamosth, 19926 1 🖾 M 2 🗆 F Maryland 219-16-2651 84 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10a. State 10c. City. Town or Location must be notified at be filed within 72 hours after death with the Maryland Director Queen Anne's Anne Arundel 1 Yes 2 x No Stevensville Md. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral , or items 23a 21666 U.S.A. 500 Bayside Drive Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: White "natural" 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Stanislawa Wanda Pasek Stanislaus Juchno 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 625 South Curley Street Baltimore, Md. 21224 19a. Informant's Name/Relationship (Type, Print) Bernard Juchno / Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rosary Cem. 20c. Location - City or Town, State 20a. Method of Disposition December 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 31,2010 |Baltimore,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 1201 Dundalk Avenue Baltimore, Md.21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final v smms r Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death sate has been signed by the spage 2 should be detached it g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perforn completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕍 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred hours after death. Ineral Director: After injury 5 Pending 2 Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as dated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer 032086 Sorve 208 15, Donah Drin Chite, Me 21619 30. Name and address of per filed (Month, Day, Year) N 0 4 2011 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

arke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Killinger Month John Michael 30, 2010 10:40 A M DECEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CENTER TOW SON SAINT JOSEPH MEDICAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 23, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Sex 1XXM 2 ☐ F **Funeral** Months Days Hours 219-80-2528 52 1958 Director Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland **Funeral Director** 1 ☐ Yes 2 X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 Paula Place United States #1A 21237 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces? Black, White, etc. ò þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: White If Yes, Give Year or Dates. "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Delivery Driver Retail 4 traumatic event, Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy important: If item 27 is marked oth any injury or other trees. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Shepherd Robert Killinger Harriet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Paula Place #1A, Mark Killinger / Brother Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Uniformed Sers. Univ. 01/03/2011 4 X Donation 5 ☐ Other (Specify) Bethesda, MD 22. Name and Address of Facility d Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ENCEPHALOPATHY ANOXIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhysician and use as the burial-transi NEUMONIA that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 L 9 Unknown 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be CARCINOMA OF TONGUE 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Wo 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 2 No Hospita Other: 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month) D 24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON MARYLAND DRIVE

DHMH 17 Rev 7/2009

State Registrar TIMOTHY LOW

7604 OSLER

MID.

32 Podistrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mary		artment of H tificate of D		-	giene Reg. No. 201	0 4 1575	
			Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death	
	Physicia Medic	al	Tae Kyung Kim				Decembe	er 31, 20°	10 10:15 P. ^M	
	Examin	er	4a. Facility Name (if not institution, give street and number) Gilchrist Hospice		4b. City, Town, or Towso i	Location of Death		4c. County of E	ltimore	
	Funeral Director		5. Social Security Number $ \begin{array}{c c} \text{ 6. Sex} & \text{7. Age (In} \\ 220067891 & \text{1 } \ \ \ \ \ \ \ \$	yrs. last birthday) 57 rs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day July 13, 1	9. 953 Sc	9. Birthplace (State or Foreign Country) South Korea	
	land show dat	_	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Loc	cation	· · · · · ·			10d. Inside City Limits	
	//arylan 8a-f sh tified a	Director	Maryland Baltimore		Ltimore				1 ☐ Yes 2 🔀 No	
	with the Ns 23a or 2	Funeral Di	10e. Street and Number 9703 Britinay Lane		10f. Zip Code	21234		10g. Citizen of What United S of Americ	tates	
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates.	1	Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 🔀 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, V	American Indian, Vhite, etc. Korean	
Maryland 21215-0036	ithin 72 hour ene. • than "natu he Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give i	ent's Usual Occupa kind of work done d O NOT use retired)	uring most of work	king	16b. Kind of Busine		
land 2	should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the Ma	To Be (17. Father's Name (First, Middle, Last) Yoo Sung Kim		II elipioy	18. Mother's Nam	ne (First, Middle, I Suk Eun	Maiden Surname)	110	
	12 should lith and M 27 is mar r traumati	1	19a. Informant's Name/Relationship (Type, Print) Mr. Jin Kang/ brother—in—law					City or Town, State	, Zip Code) Land 21030	
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		1 V Rurial 2 Cremation 3 Removal from State	20b. Place of Dispo cemetery, cren Woodlawn	natory or other place		uary 4,	20c. Location - City	y or Town, State	
Balti	permit. F Departm Importa any inju		21. Signatural Service accensee		Name and Addrese A	lternative	es Funer	al &Cremat	ion Ctr.,P.A.	
	h sician/		23a. Part . Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
مبدو	Medical Examiner		disease or condition resulting in death) a. Due to (or as a co	nsequence of):	ruce -					
	ed	Examiner	Sequentially list conditions, if any, leading to immediate Luctual Charles of Cause (Disease or linjury)	nsequence of):						
0	ate be executed ohysician and the burial-transit	dical Exa	that initiated events resulting in death) Last C. Due to (or as a co	nsequence of):						
68760	ificate ng phy as the	Medi	IF FEMALE:							
Вох	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi		23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date o Month	f delivery Day Year	
Js, P.O.	requires that the de been signed by the should be detached	ed by Ph	Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.		bacco use contribut	te to the cause of death?	
Division of Vital Records,	The law rec ate has bee page 2 sho	Completed					24a. Was a autop perfor 1 Yes	sy prior deat	e autopsy findings available to completion of cause of h? Yes 2 □ No	
ıta	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatier	Othe	ace of Death (Chec	ck only one)	ence 6 X Other (S	Massice	
of/	ing Phy ing Phy ineral d	ate: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Ye	28b. Time of	28c. Injury work	at ?		ow injury occurred	pecity) Hospical	
ivisior	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - building, etc. (S)	At home, farm, stropecify)		Yes 2 No	28f. Location (Single City or Town		r Rural Route Number,	
Ω	Hospital 24 hours Funeral leted filled	Medical	29a. Certifie 1 Certifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of exam only bne) Certifying Nurse Practioner: To the best	ination and/or invest	igation, in my opinio	n, death occurred a	at the time, date ar	nd place, and due to	the cause(s) and manner stated.	
	To the vithin To the compl	Σ	29b. Signature and the of certifier	Of my knowledge, C	29c. License	number		29d. Date signed (M		
				(ham 00c) 75 = 5	D00	11287		11/11	21100	
	TV		30. Name and address of person who completed cause of death	W. Che	les St.	SuchE	4105,	Baltin	ere; MD	
	Stat Registra		31. Date filed (Morth, Pay, Year) 32. Registrar's 3	Signature face			(

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Richard Kirk December 2010 11:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Months Days Hours (Month, Day, Year Country)
Marvland Director 216-20-0649 82 9 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Harford Pylesville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2125 Harkins Road <u> 21132</u> 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. than "natural", or 1 Never Married 2 Married Š If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineers Local Union permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygie Important: If item 27 is marked other I Heavy Equipment Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Theodore Kirk Gladys Irene Frantz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna L. Kirk / Wife 2125 Harkins Rd., Pylesville, MD 21132 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State K Burial 2 ☐ Cremation 3 ☐ Rem al from State Air Memorial Gdns: Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Si nature of Funeral 50 W. Broadway, . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury cate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rknows performed? Yes 2 No 2 🗀 No 1 Yes Hospital or Attending Physician; 24 hours after death. ision of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 5 Pending Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier List a Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction of Lathieus at a my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatur 29c. License number D0053568 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person OMPSON Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 2"29 PM M 21, 2010 Marion F. Kotowski <u>December</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 4300 Cardwell Avenue #318 Baltimore | Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug 20, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗓 F Connecticut 86 046-18-1603 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the fredical Examinat must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4300 Cardwell Avenue #318 21236 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: þ Specify: white 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within th and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 healthcare phlebotomist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Hersa Lomas Thomas Fitch Raymond ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 N. Branch Road Baltimore, MD 21222 Health atem 27 ls Ray Kotowski/son permit. Pages 1 ar.
Department of Heal.
Important: If item 23
any injury over 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signatus of Fineral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 23a. Part . Enter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line. Immediate Lause (Final disease or conditions) Baltimore, MD 21201 Approximate Interval Between Onset and Death Physician Longartive disease or condition resulting in death) /Medical Due to (r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician a the burial-Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 ☐ Yes 2 14/10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Nesidence 6 ☐ Other (Specify) Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

The law requires that the death certificate be executed Box 68760. P.O. I the signed by tage of Vital Records, this certificate To the Hospital or Attending Physician: eral Director: After th filled in by the funeral Division death. 24 hours a within 2 To the

death with

72 hours after

within

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

1005 North PS.W 82. Registrar's Signature

and manner stated.

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0-41399

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ December 2010 10:23 AMM Peggy L. Kimmey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester 3603 Karen Circle Linkwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea July 28, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Hours Months Maryland 1 - M 2 1/2 F 213-42-0003 Director 67 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "nature!"
any injury or other traumatic events. 10b. County 10c. City, Town or Location 10a, State **Funeral Director** 1 Yes 2X No Linkwood Dorchester MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21835 3603 Karen Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married white 1 ☐ Yes 2 🕅 No Specify: Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) food industry waitress 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola Marie Wroten 2 Emmett Monroe Gore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1205 Race Street Cambridge, MD 21613 Penny Carpenter/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🂢 Other (Specify) in state 21. Signature of Europal Service I censee Wade State and And to Africa Board 655 W. Baltimore Street Director MD 21201 Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus non each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sclelo 400 Physician ear disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Ao Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Emphesema, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Yo 24a. Was an autopsy Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000 6

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person

31. Date filed (Month, Day, Year)

101

101

who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar amend #8 Per ANA BD Cog in cate of 2014 JH Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Month Day am William Kells Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death raky/and Grenera TIMOTE Date of Birth 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Min Maryland 1 🕅 M 2 🗆 F Yrs Director 215-40-5941 68 1942 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1√ Yes 2 □ No MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 1311 N. Stockton Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes. Give Specify: black 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 truck driver State of MD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lilae Ganney Willie Kells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3116 Oakley Avenue Baltimore, MD 21215 Lilae Carter/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place T 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 □ Donation 5 ▼ Other (Specify) in state 1/7/2011 Balto.,MD On Site Cremation 22 Name and Address of Facility James A Morton S POI Laurens ST 1201 Co., MD 21217 I Funeral Survice / censee Morton &Sons F.H. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final ≺ Pnysician/ ancreatic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) signed by the attending physician and ibe detached for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director After this certificate has t completed filled in by the funeral director, page 2 s completed filled in by the funeral director, page 2 s autopsy performed Yes 2 death? 2 🗆 No 25. Was case referred to medical exampler?

1 1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural Natural 5 Pendina work?
1 Yes 2 No Accident Investigation M Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Mydical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) sompleted cause of death (Item 23a) (Type, Print) 30. Name and eddre ss of person who 1aRy/and 31. Date filed (Month, Day, Year) JAN 0 4 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🍴 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carol G. Kiburz Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Plata Modica 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 ☐ M 2 🏋 F Month, Day, Months Davs Hours Min. New Jersey Director 89 Ja'n 482-34-2750 Usual Residence of Decedent 10c. City, Town or Location 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10665 Horseshoe Court 20646 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, was becedent Ever in 0.5.
Armed Forces?
1 X Yes 2 □ No 1943
If Yes, Give
Year or Dates. Black, White, etc ģ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Health Care Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Harry L. Gordon Grace Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 10665 Horseshoe Court La Plata, Maryland 20646 Connie S. McClanahan, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 12/31/10 Baltimore, Maryland Signature of Funeral Service Liegnsee Thomas Gregor emation Society Of Maryland, Inc. 9 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transi or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death. Director; After this certificate has autopsy performe death? 1 Yes 2 No 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 🗌 Yes Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated pleted cause of death (Item 23a) (Type, Print) Stlv 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 04 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ida S. Lindsav Month 2:55ам Dec 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Towson Baltimore Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Min Month, Day, Yea 1 M 2 X Hours 213-03-7578 95 Yrs **Director** MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Director MD Baltimore 28a-f Middle River 1 Yes 2 No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Innovant of Health and Mental Hygiene. Innovant: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be once. Funeral 9413 Windpine Road 21220 USA death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify White Completed 3 Widowed 4 X Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Franklin P. Lindsay Effie Bell Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Mayfield/Niece 9413 Windpine Road Baltimore MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of 20c. Location - City or Town, State Page 1; cometery, crematory or other place)
Bayview Crematory 12/30/10 1 Burial 2X Cremation 3 Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 300 MAce Ave. Balto. MD allets Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final) Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): as the burial-transi Cause (Disease of injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? detached for 4 ☐ Pregnant at time of death g ☐ Unknown the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 ☐ Yes 2X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD JACKIE JONES TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar recen

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DECEMBER

LINDSAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 4 United Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29 ZOIC Physician/ 3:27PM 4a. Facility Name (if not institution, give street and number Medical 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford 1701 Mountain Road Joppa | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Feb. 47 | 1947 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F 214-46-8813 Mary Land Director 63 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21085 USA 1701 Mountain Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 XYes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: 3 - Widowed 4 - Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arvil (nmn) Lyon Elsie M. Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Jackman / Sister 119 Brightside Avenue, Pikesville, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Gremation 3 ☐ Re 4 ☐ Donation 3 ☐ Other (Specify) Mountain Christian Chr. 1-3-11 Joppa, Maryland 21. Sim arure of Fure a Scrvice McComas druneral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Coron any disease or condition Medical resulting in death) Due to (or as a consequence f): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events le alem burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \bowtie Residence 6 \square Other (Specify) 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After **Natural** (Month, Day, Year) 5 Pending work? 1 Yes 2 No Investigation Accident 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12.30.10 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PERRY POINT MITTAR NO. VAMHC 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State

Registrar

JAN 0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 3:25 A December LeFaivre Helen 0. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral July ^{Year} 1920 Hours 1 🗆 M 2 🔀 10 Marvland 218-18-3183 **Director** 90 Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Director 1√ Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be by Funeral United States 21212 435 Rosebank Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Army 12 Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Carol Owsianiecki Pelagia Rakewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michele Lynne LeFaivre/daughter 435 Rosebank Avenue Baltimore, Maryland 21212 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 1/3/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Sign re of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD thomas M00957 wita 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of). resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) 2 **N**ON0 detached Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No page 2 certificate has 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No death Accident Investigation after death in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours aff

To the Funeral Di

completed filled in 24 hours a Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier be al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nature and

State Registrar

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Date filed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 0071187 29d. Date signed (Month, Day, Year)

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Paul William Loewer	State of Maryland / Department of Health and Me	ntal Hygiene	
1- For State Registrar	Certificate of Death	Reg. No.	
	- Nov. (Circl Stiddle Lock)	2 Date of Death	3 Time of Death

		Registrar		Cert	tificate o	Dealli					eg. No.				
Physicia dical Examin	ner	1. Decedent's Name (First, Middle,Last) Paul William Loewer								Date of Death Month Day Year December 30, 2010				3. Time of Death 0605 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 3751 Timahoe Circle Perry Hall - Nottin								nam		. County of altimore		nty	
Funeral Director		5. Social Security Number 212-76-9712	6. Sex 7.	Age (In yrs. la	ist birthday) Yr	Months s.	Year Days	If Under Hours	24Hrs. Min.	8. Date of Bi June	,	1	Foreign	nplace (State or n Intry) Mary Land	
-UU36 i within 72 hours after death with i within 72 hours after death with rgiene. ther than "natural", or items 23, ther than "natural"	Be Completed by Funeral Director	10e. Street and Number 3751 Timahoe C 11. Marital Status 1 Never Married 2 XM	12. Was Deced Armed Force 1 Yes vorced If Yes, Give Yaar or Dates: colfy only highest grade College (1-4 1	Was Decedent Ever in U.S. Armed Forces? Yes 2 Noss, Give Yaar alse: ghest grade completed) College (1-4 or 5+)		Ty Hall- Nottinghal 10f. Zip Code 21236 Vas Decedent of Hispanic Origin? (Spires, specify Cuban, Mexican, Puerto Yes, 2 No specify: ent's Usual Occupation (Give kind of working life. Do NOT use retirete Sales			n? (Spec Puerto Ri nd of wor se retired	specify Yes or No- o Rican, etc.) work done tired) H—S te (First, Middle, Maiden		USA 14. Race - Americ White, etc. Specify: W 6b. Kind of Business/Ir		ican Indian, Black, White Industry	
permit. Pages I and 2 should be file. Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, th	٩	19a. Informant's Name/Relation Rebecca H. Loev 20a. Method of Disposition 1 Burial 2 Crematio 4 Donation 5 Other S 21. Signature of Funeral Service	3751 Place of Disportermatory or on aklawn	sition (Name of cemetery, ther place)			le 1-4- Schi	Perry Hall Date 2000 -2011 Ball imunek Fund		11-Nottingham, Md. c Location - City or Town, State alto. Md. neral Home		gham, Md.21 Town, State			
Physician un and property in transit property in transit property in the prope	Examiner	23a. Part I. Enter the disease, o failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	a. Atherosclero Due to (or as a co	tic Cardiova onsequence of onsequence of	ascular Di									Approximate Interval Between Onset and Death	
es that the death cert igned by the attendin		IF FEMALE: 23b. Was decedent pregnant in 1 past 12 months?	he 23c. If yes, ou 1 Live birt 4 Pregnar g Unknown	nt at time of dea	2	etal death Other (Specify underlying ca			pregnand t I.	23e. Did to 1 Ye 24a. Was auto	iobacco es 2	No 3	pute to i	he cause of death? ably 4 V Unknown topsy findings available ompletion of cause of	
DIVISION OF VICENT RECOVERS, related to Attending Physician: The law requirers after death. a) Director: After this certificate has been so led in by the funeral director, page 2 should led.	To Be Com	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	Hospital: 1 Inp		ER/Outpatier	nt 3 DO/	10		Nursing	1 Yes	Reside	ence 6	_		
or Att after de Directe	Certification:	27. Manner of Death 1 V Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined												ral Route Number, City	
To the Hospital or within 24 hours afte To the Functal Discompletely filled in	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner stater	examination ar	ge, death occ nd/or investig	ation, in my o	me, date pinion, d icense	death occ	ce, and di	ue to the cau	29d.	ace, and du	d (Mo	e cause(s) nth, Day, Year)	
St	ate	30. Name and address of person Donna M. Vincenti, M. 31. Date filed (Month, Day, Year JAN U 4 2011	ID Assistant Me		niner 900	O W. Baltir	more S	Street, I	Baltimo	ore, MD 2	1223				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Leroy Albert Lonesome Jr. 11:03 AM Pumb 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Baltmore Hospit Birthplace (State or Foreign Country)
 PA **Funeral** 7. Age (In yrs. last birthday If Under 24 Hrs. Hours Min. 8. Date of Birth Days 1 ₹M 2 ☐ F Months 0792797941 69 Director 219-38-1889 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4305 Miami Place 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify. 3 Widowed 4 Divorced Completed Year or Dates Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steelworker Armco Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Winifred Montgomery Leroy Albert Lonesome Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Britni Lonesome-Granddaughter 4210 Brookside Caks Rd. Ovings Mills, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 01.06.2011 Baltimore, MD ign ture of Funeral Ser John L. Williams Funeral Directors, 4517 Park Heights Ave Baltimore, MD P.A. 21215 Park Heights Ave Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph. sician/ disease or condition resulting in death) Failure da Medical Due to (or as a consequence of): **Examiner** Epilept Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a con equence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? ò Month 4 Pregnant at time of death 9 Unknown Yes 2 No 9 Unknown P.0. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 performed Yes 2 No 1 Yes 2 No 25. Was case referred to edical Be 26. Place of Death (Check only one) Hospital 2 M No မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manne f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending injury 1 ☐ Yes 2 ☐ No М Accident Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) within 24 hours a

To the Funeral D Medical 29a. Certifier 1 🔍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Hospith of Boltimos Sinai 31. Date filed (Month, Day, Year) State **JAN 0 4** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death 2. Date of Death 3. Time of Death Month December Physician/ Medical 4a. Facility Name (if not institution, give street and number 4c. County of Deatl **Examiner** Kandallstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 92 Months Davs Hours Director 219-01-8848 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD **BALTIMORE** BALTIMORE 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21208 725 MT. WILSON LANE, #532 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 2 1 Never Married 2 Married Yes 2XXNo Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates. Completed 3 ¥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME **HOMEMAKER** Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 **JOSEPH** TUCKER SOPHIA GUMENICK 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7928 LONG MEADOW ROAD, BALTIMORE, MD 21208 JOYCE KAPLAN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM. 01/02/2011 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Ligense PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between Onset and Death Immediate Cause (Final Physician/ 10 ps. S disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner neuhonia Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury signed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Failure Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed Director: After this certificate has been so he has been so he has the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be (26. Place of Death (Check only one) Hospital 은 1 Nupatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? Natural injury 5 Pending 2 🔲 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 053850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) teles M.D. Juliwort 31. Date filed (Month, Day, Year)
JAN 0 4 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month December 30, Physician/ 8:05 AM 2010 Carole Helene McCready Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Center for Hospice Care Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6 Sex 7. Age (In yrs. last birthday, **Funeral** (Month, Day,) Aug 09 Days 1 M 2 DEF 66 Maryland 1944 **Director** 218-42-3184 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 ☐ Yes 2 No Cockeysville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Completed by Funeral items 23a United States 21030 511 G Lake Vista Cir. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status other traumatic event, the Medical Examiner Armed Forces Black, White, etc. ò 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify. Yes. Give White 3 Widowed 4- Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Legal 12 Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o မ Helene Sewell Elmer Mack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Lisa Malick /Daughter 1712 Monkton Farms Dr. Monkton, MD 21111 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec 31 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a co quance of): **Examiner** Sequentially list conditions, hearly, leading to in reduct cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans and Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No page 2 should be detached 9 Unknown 9 Unknown P.0 Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: ည 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 \square No Investigation Accident hours after dea ineral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only

State Registrar 29b. Signature and

31. Date filed (A

onth, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

32. Registrar's Signature

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29^{ay} Dec. 20 TO 7:45 pM Catherine Francis Messenger Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 10119 Bird River Road Middle River Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 217-01-4131 92 Months Hours NOV . 17 Pear 918 MD Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Middle River MD Baltimore 1 Yes 2 X No 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō Examiner must be Funeral 23a 10119 Bird River Road 21220 USA items 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ō ģ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White "natural", 3 XWidowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. Do NOT use retired)
Meat Packer 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry of Health and Mental Hygiene.

Item 27 is marked other than "
other traumatic event the Man Elementary/Seconday (0-12) College (1-4 or 5+) Esskay 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Griffith Minnie Yeager Page 1 and 2 should be f 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1534 Tieman Drive Glen Bernie MD 21061 John Messenger Jr. son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Belair Memorial 1/3/11 Belair MD Other (Specify) 4 Donation 5 300 MAce Ave, 21. Signature 22. Name and Address of Facility Balto. Connelly Funeral Home of Essex 21221 4 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Ph_sician/ al theimer's disease or condition resulting in death) URS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month 5 Other (specify) the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0053641 12.30.2010 30. Name and address of person who sompleted cause of death (Item 23a) (Type, Print) 301 Eastern Blud. Ste. BBaltmore MD 21221 Michelle Juaneta MD 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 11:55 PM Andrew Morrow December 25, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Genesis Multimedical Center Towson, Maryland 21204 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 213-38-6488 April 13, 1940 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State show ns 23a or 28a-f shor 1 √es 2 No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15/ Funeral 91930 Warren 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status ed other than "natural", or iten event, it e Medical Examiner and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ Specify. 3 ☐ Widowed 4 ☐ Divorced M Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry in item 27 is marked other than "no re other traumatic event "". Elementary/Secondary (0-12) College (1-4or 5+) and SCaping home (First, Middle, Maiden Surname) 19 17. Father's Name (First, Middle, Last) Be ို Bernard Hookew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister 19a. Informant's Name/Relationship (Type. Print) Point 0 20c. Location - City or Town, State 6000 Ja1906 Maynes 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Conation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If it any injury or o CAPMENTAL nood 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Approximate Interval Between Onset and Death 23a. Part - Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease of condition resulting in death)

a. Metastatic Laryngell Cancer to liver and lun pue to (or as a consequence of): metastatic Laryngeal Cancer to liver and lung April 2009- now **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Obstructive Pulmonary Diserse; Completed Squemous Cell Skin cancers of nose wrist, and right chest 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an as well as forehead, left upper arm; Progressive Weight Loss due to carrier 2 110 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 ☑ No Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Mannes of Death Injury 1 Natural 5 ☐ Pending investigation ours after death.

neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I Nurse Practitioner 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Michelle E. Kalendek CRNG R097104 12/28/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle E. Kalendek, CRNP Genesis Multimedical Center 7700 York Road Towson, Maryland 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN U 4 2011 barket Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 1tem 6 per fh 2911 1-4-11 vt

State of Maryland / Department of Health and Mental Hygiene Amend Item 1 per DVR/spouse G911 1/21/11 dk Certificate of Death State Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 802AL MATTERN 01:5 **9** M Medical ecember 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Glen Burnic Anne Arunde timore Washington Medicul 8. Date of Birth 14 O 3 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday) Funeral 1 XM 2 31 Days 194<u>3</u> 40 1512 Director 67 Usual Residence of Decedent 10a. State or 28a-f show 10b. County 10c. City, Town or Location death with the Maryland must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 23a Funeral 242 Meadow Road 21122 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items? any injury or other traumatic event, the Medical Examiner mussonce. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 🗷 No 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Kopflex Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Albert Mattern Effie Doris Norwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 242 Barbara Mattern - wife Meadow Rd. Pasadena, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 S Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Bayview Crematory 12/31/10 Baltimore, 21. Signature of Furnial Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home Pasadena, Riviera Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ 2E641C SHOCK DAY disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** 2 PAG S AIU OM UZUS Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year 2 No 1 ☐ Yes 2 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law Jas performed? Yes 2 No 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ဂ္ 1 Na Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 24 hours after death Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Dis Brim José acingues D00 85+1A DECEMBEN 34, 5010 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUILLERMO TOSE GIANCAECO 301 HOSPITAL DRIVE, GLEN BURNIE, MD 20161-5803 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 4 | 592 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 Month Day FRANCIS JOSEPH MARTIN, SR. 22 2010 6:03 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 185 Carroll Road Pasadena Anne Arundel 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 D F Months Days Hours Min 05 30 **Director** 220 20 5134 82 MD Usual Residence of Decedent shov 10a. State 10b. County within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel 1 🗆 Yes 2 🔽 No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 185 Carroll Road 21122 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify. 3 x Widowed 4 ☐ Divorced Completed Specify Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore <u>Utility Supervisor</u> <u>Gas & Electri</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Thomas F. Martin Marv Nagel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jo Wiley - daughter 441 Hardmore Ct. Glen Burnie. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 12/28/10 Glen Burnie, 21. Signature of Foreral Price Licensee 22. Name and Address of Facility GJ Gonce Funeral Home 169 Riviera Pasadena, Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death DAM disease or condition Monte Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) sician and burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျု 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 39505 December 22, 2010 leans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yudhish Markan 305 Hospital Dr. Glan Burnie, MD. 21061 SV 32. Registrar's Signature Registrar ark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** William Richard Marriott 0343AM December 27 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Agnes Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 9, Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 □ F Months Days Feb. 218-36-9500 1939 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County d other than "natural", or Items 23a or 28a-f show event, It a Medical Experience and the redified at MD 1 ☐ Yes 2 ▼ No Director Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2031 Edmondson Avenue 21228 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White ۵ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Superindentent Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William C Marriott Elsie Stanley 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2031 Edmondson Ave., Trisha Frick - Daughter Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 X Cremation 3 ☐ Removal from State Jan.1,2011 5 Other (Specify) Atlahlic Crematory Glen Burnie, MD Signature 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aspigation **Physician** days neumoni disease or condition resulting in death) /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transite with a filled in by the funeral director, page 2 should be detached for use as the burial-transit. Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. | 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an perform 1 □Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 212 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours after
To the Funeral Dire 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Avenue saltimore. 32. Registro's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29,2010 December 10:12 P M Margaret D. Mover Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Brightview Asst Living of Catonsville Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 25 1925 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Hours Country) Connecticut Director 046-14-9753 85 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 912 21228 Rolling Road 216 USA Apt items 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No WW11

If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, , or P Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: "natural" Completed 3 X Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) the 12 <u>Homemaker</u> Own Home Department of Health and Mental Hy, important: If item 27 is marked other any injury or other **** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman Everett Draper Helen Isabelle Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5167 Viaduct Avenue Relay, Maryland 21227 Joyce Hall-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place). Restarden Memorial. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan.3,2011 Frederick Maryland 21. Signal of uneral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home Inc. atmi CAURARE 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Emphysem A (or as a consequence of): 10 yrs Medical resulting in death) Due to (or as a c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam burial-transit Cause (Disease or finjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Rheumarois ARTHITIS 2 No 3 Probably 4 Unknown 1 Yes Completed Hypertension Essential 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 🛮 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 29b. Signature and title of certifier Joseph H Miller MD December 30, 2010 06982 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455 WILKENS AVE Suite 203 Miller ma 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN O

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#20b&30 Per FH G911 1/04/2011 IIII
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 30 2010 Physician/ McLEAN 4:35 P M WILLIAM E. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner CARROLL COUNTY HOSPITAL CENTER WESTMINISTER CARROLL g. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** Days 09/21/1944 Hours 1 🕅 M 2 🗆 F 66 Director NC 213-44-6385 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 **½** Yes 2 □ No N/A **BALTIMORE** MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 3905 PRIMROSE AVENUE 21215 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1

Yes 2 □ No
If Yes, Give Black, White, etc 2 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed Year or Dates ا 16a. Decedent's Usual Occupation الأعناء kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed, and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) TRUCKING DISPATCHER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) popariment of Health and Monte Important: If item 27 is marked any injury or other remonents. ည **IRENE** ALLISON **THOMPSON** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3905 PRIMROSE AVENUE, BALTIMORE, MD 21215 JOANN McLEAN/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition ANSHE EMUNAH ATTO CHAIM CEMTERY Cem. 01/02/2011 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE. 21. Signature of Fune 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD. MD 21208 PIKESVILLE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine ue to (or as a if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23h. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregna5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? this certificate has I performed 1 ☐ Yes 2 ☐ No the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 Yes Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatl 8 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопретен Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

82. Registrar's Signature

Baltimore, MD 21237

Ajay Behari 9000 Franklin Drive

31. Date filed (Month, Day, Year)

JAN 0 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month C Physician/ 7:30 ETHEL L MEYER AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4730 ATRIUM COURT, #468 BALTIMORE OWINGS MILLS 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1272771921 89 Director 200-16-0775 Usual Residence of Decedent or 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗆 Yes 2 😾 No OWINGS MILLS MD BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4730 ATRIUM COURT, #468 21117 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces? Black, White, etc. ъ þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates WHITE "natural", Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b, Kind of Business Industry al Hygiene. I other than " life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Heatth and Mental H fitem 27 is marked ot r other traumatic even permit. Page 1 and 2 should be 1.
Department of Health and Mental Important: If item 27 is more any injury or other. 2 MOSKOVITZ MAX DENA BALDINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACK MEYER/HUSBAND 4730 ATRIUM COURT, #468, OWINGS MILLS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State JUDEAN MEMORIAL GDNS: 01/02/2011 4 Donation 5 Other (Specify) OLNEY, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mast Le 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Due to () as a consequence disease or condition Medical resulting in death) Examiner Steno Acrtic Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 12 Hesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 7/2009

JAN 04 Registrar

(Check

29b. Signature and title of certifier

filed (Month, Day, Year,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rothschild

4000 Old Court

3

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Run Ra.

who completed cause of death (Item 23a) (Type, Print)

797400 (217 Stemmer 5

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20a-c, 22 per Fh 9911/4/11 TT
State of Maryland / Department of Health and Mental Hygiene [] | [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Lillian Maddox November 20 2010 P^{M} 9:07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 205 Harry S. Truman Drive Prince Georges Upper Marlboro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 3, Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Vĭrginia 577-90-7104 Director 87 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Prince George's Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20774 205 Harry S. Truman Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No ρ white Specify: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife 9 own home of Health and Mental Hygiv Item 27 is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence Stephens William Ernest Hynson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2601 Rigging Drive Annapolis, MD Charles Hynson/brother 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 22. Name and Address of Facility Cedar Hill FH 4111 PA Ave. State Anatomy Board 655 W. Baltimore Street 4 ☐ Donation 5 MOtho state Riverdale Crematory 21. Signature of Funeral Service Licenses Ronald S. Made Director Suitland, MD 20746 Baltimore, ΜĎ Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca e (Final disease or condition resulting in death) Atherose **Physician** Pis ena /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 2 No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1☐ Yes 2☐ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Médical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Nakshian 10:50 PM December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brookgrove Assisted Living Ctr. Sandy Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept • 5 Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Year 1915 Months New Hampshire 95 Director 286-07-6456 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 23a-f shov 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2XX No Montgomery Sandy Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20860 1641 Hickory Knoll Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Federal Government / College (1-4 or 5+) Elementary/Seconday (0-12) System Commander U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Yepremian Mary .Iohn Nakshian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20906 3533 Twin Branches Dr. Silver Spring, MD Marie Roe / Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Chesapeake Crematory! 1/3/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungal Service Itemsee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final PNEWMONIA Physician hours Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, teaching to intime unate cause. Enter Underlying Due to for as a consequence of, Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death should be detached the 9 Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed page 2 s has 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Division of Vital director, 26. Place of Death (Check only one) Be Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) မ funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation after death Director: the 6 Could not be hin 24 hours after de the Funeral Directo mpleted filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010

DHMH 17 Rev 7/2009

State

Registrar

IED E. HOWE

Date filed (Month, Day, Year)

JAN 0 4 2011

WHY AMSPORT.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

10-09854

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Anthony Leroy Nicastro 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day December 21, 2010 Nicastro 1355 hrs **Medical Examiner** Anthony Lerov 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery 24800 Block Hipsley Mill Road Gaithersburg 5. Social Security Number 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) Age (In yrs. last birthday) **Funeral** oreign Country) 1 X M 2 F 48 Days 119-56-7432 Months Hours 01/27/1962 New York Director Usual Residence of Decedent 10c. City, Town or Location Gaithersburg 10d. Inside City Limits 10a. State 10b. County and MD Montgomery 1 Yes 2 No 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 20882 6310 Damascus Rd. 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces Never Married 2 Married Yes White 1 Yes 2 No specify: 4 XX Divorced If Yes, Give Year Specify Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Wood Working Craftsman Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) Elizabeth Yurasits .17. Father's Name (First, Middle, Last) Leroy G. Nicastro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $12904\ Victoria\ Heights\ Dr.\ Bowie,\ MD\ 20715$ 19a. Informant's Name/Relationship (Type, Print) Elizabeth Yurasits (mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Dec. Date 29. 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 2010 Donation 5 Other Specify: 22. Name and Address of FacilityRapp Funeral & Cremation Service 21 Signature of Funeral Service Licensee M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line **iMedical** Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed und cian/Medical UNPENDED AMENDED ending physician use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed After this certificate has been suneral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No 5 Pending death. the 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 [6 Could not be Suicide or Town, State) determined within 24 hours a To the Funeral I 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. December 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN U 4 201

DHMH 17 Rev 1/2001 OCME 2006

Registra

Please Type or	Print in Black Indelible	e Ink. Ensure Al	l Copies Are Legible	<u>.</u>
State	of Maryland / Department	of Health and Me	ental Hygiene	

		-	For State Registrar		State of Ma	ryland /	•	tment of ificate of			ental Hy	giene Reg. N	2010	41601
			Decedent's Name	e (First, Middle,	Last)						2. Date of De	ath	-	3. Time of Death
	Physicia Medic		Edwa	rd J. Na	adolny, Sr.						Month	30		5 8:29 AM
	Examin		_		ive street and number)			4b. City, Town,				- 1	c. County of Dea	
	Formani	М	Front 5. Social Security N		Sex 7 Age	In yrs. last b	pirthday)	KOSE If Under 1 Year		der 24 Hrs.	8. Date of Bir	th	3altin	YOCC rthplace (State or Foreign
	Funeral Director		220-20-82	292	5. Sex 1 M 2 □ F 82	m yro. raot x		Months Day			May 12	y, Year)	28 M	aryland
	d t ow		Usual Residence of 10a, State			10c. City, To	01 000	tion						10d. Inside City Limits
	aylan a-f sh fied a	Director	Md.	Tob. County	Balto.	ruc. Gity, ic		ry Hal	1					1 ☐ Yes 2 🔀 No
	he Ma or 28a or otii	Dire	10e. Street and Nur	nber	Daito.		161	10f. Zip Code				10g. C	itizen of What C	
	with t	Funeral	16 "L" 1	Brook Fa	arm Court			211	28				USA	
d ward	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Marr 3 Widowed	ried 2 Marrie	12. Was Decedent Ev	0		as Decedent of Yes, specify Cu			ify Yes or No- lican, etc.)		14. Race - Am Black, Whi Specify:	
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2 C	ithin 7 ene. r than	Completed	Elementary/Sec I 2 t h	onday (0-12)	College (1-4 or 5+)]		NOT use retire Superv				Ref	rigerat	ed Warehouse
	iled w Il Hygi other	Be	17. Father's Name (First, Middle, La	st)				18. Mc	other's Name	(First, Middle,	Maiden	Surname)	
> 2	d be f Menta Menta arked atic e	욘	John J.	Nado1ny	,Sr.					Viola	Wilczy	nsk	i	
Many C	shoul and l		19a. Informant's Na					,					or Town, State, Z	
	and 2 Health em 27 ther to		Lo1a T. 20a. Method of Disp		y spous			"L" Br	ook I	1	ourt l	_	y Hall,	Md. 21128
0 9	age 1 ent of nt: If it		1 XBurial 2		Removal from State	ceme	etery, crema	tory or other p		1-4-20		ļ	to. Md.	Town, State
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à	o a m de		144	tel	9		9	705 Be	lair	Road	Nott	ingh	am, Md.	21236
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	Medical		resulting in death)	1	Due to (or as a	consequenc	1	3						
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	exectian an	EX	resulting in death)	Last	Due to (or as a	consequenc	e of):							
9	cate be executed physician and sthe burial-transit	edical			a. <u>H. C. V.</u>	D.								
Bov 687	death certifiine attending	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 [9 Unknown	months? ☐ No	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	☐ Fetal de		Ectopic pregna Other (specify)					23d. Date of de Month	elivery Day Year
٥	uires that the signed by	by	Part II. Other signif	ficant condition	s contributing to death but	t not resultir	ng in the und	derlying cause	given in P	art I.				o the cause of death?
Division of Vital Becords	The law req	Completed									24a. Was auto perfo 1 \(\sum \text{Yes}\)		prior to death?	utopsy findings available completion of cause of es 2 No
5	ician; certific ector,	Be	25. Was case referre	,	Hospital:			10	ther:	Death (Check				
>	Phys r this eral dil	e: To	27. Manner of Deat	No h	1 🗌 Inpatier 28a. Date of injury	281	o. Time of	28c, In	urv at		ne 5 ∐ Resi 8d. Describe		6 Other (Spe	cify)
2	ath. r: Afte	icat	1 Matural 2 Accident	5 Pending Investiga	ition	Year)	injury		orḱ? □ Yes 2	□No				
jajvio	ial or Atters after de al Directo	Il Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin			farm, stree	t, factory, offic	е	2	8f. Location (City or To			ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Medical	(Check 2	Medical Ex	Physician: To the best of maminer: On the basis of exa Nurse Practioner: To the b	mination an	d/or investig	ation, in my op	inion, death	n occurred at t	the time, date	and plac	e, and due to the	cause(s) and manner stated.
	Veith Con and		29b. Signature and	title of certifier	AP .	~~			nse numbe	762	_		ate signed (Mon	
			20 11	7mi/	VI ving-in	ツ	-) (% - 5 :		0	, ,		1.00	<u> </u>	2010
1			Dr Sur	:/ Ah	no completed cause of dea			nt) Squa	re D	cive f	3a/+i	mos	e, MD	21237
15,	Stat Registra		31. Date filed (Mont		32. Registrar	s Signature	4	,		1.74			•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 27, 2010 **Medical Examiner** DORIS L. NEXSEN 1627 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1816 Fleet Street **Baltimore** N/A 5. Social Security Number 9. Birthplace (State or **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth/MM/DD/YYYY Min Months Days Hours Director Country) 251-24-6492 1 M 2X F 85 5/30/1925 SC Usual Residence of Decedent 10b. County Ę 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show MD ii. Pages 1 and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mantal Hygiene.

'or other traums size. N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1816 FLEET STREET 21231 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 2 X No Yes 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: WHITE Specify: é 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NURSE MEDICAL YEARS 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) LESLIE DENTON Be MATTIE STONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYDIA WEBB/DAUGHTER 2217 PLANTATION RD., NE ROANOKE, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 🗶 Cremation 3 🗌 Removal from State 12/31/2010 METRO CREMATORY, INC. CATONSVILLE, MD 4 Donation 5 Other Specify 21. Signature of Euperal Service Licensee 22. Name and Address of Facility MO0217 THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line (Medical Death a. Hypertensive Cardiovascular Disease Complicated By Hypothermia ≛xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): Exa events resulting in death) Last and transit sician/Medical the attending physician a red for use as the burial -UNPENDED AMENDED P.O. Box 68760, es that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Day Yea past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Phy signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been a director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: Subject exposed to cold environment Natural FOUND 5 Pending 1 Yes 2 ✔ No Director: hours after death Dec 27, 2010 1620 hrs 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 1816 Fleet Street, Baltimore, MD determined (Specify) Townhouse / Rowhouse Homicide 29a. Certifier (Check only 1 one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 28, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10g Per FH G911 1/04/2011 Jh State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20:30 Décember 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Simai of Baltimore Haspital City Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 F 68 Hours Director 422-88-2020 Kenya Usual Residence of Decedent 28a-f show Çity, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10g. Kenyara Co Antigua 5 10e. Street and Number 23a Funeral 212-08 Richard permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items? . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 2 No Completed by 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 13/ac Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use refired) (Specify only highest grade completed) Se Elementary/Seconday (0-12) College (1-4 or 5+) VEC Be Mother's Name (First, Middle 17. Father's Name (First, Middle, Last) KNOWN ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD2120 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State atient 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Funeral Service 21. Signature of Funeral Service License: 22. Name and Address of Facility Vava ha any MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intracerebral Bleed +hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Day Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by peep Venous Artemo Disecise: thrombosis 1 Yes Records, 2 No 3 Probably 4 Unknown Hypertension, Seizure, Cerebrovascular Accident 24a. Was an 24b. Were autopsy findings available Hospital or Attending Physician: The law prior to completion of cause of death?

1 Yes 2 No , page 2 autopsy has After this certificate 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) MD RES - COO December 28. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATRINA A ABADILLA MO Sinai Hospital of Boutimore 31. Date filed (Month, Day, Year) JAN 0 4 2011 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 10.15 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lity Sinai Mospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 G F (Month Day, Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore 1 Yes 2 No Mh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 21223 USA items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic avents that it is not the traumatic avents. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. - Mece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ntonsville, mo 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens MD 21229 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final disease or condition resulting in death) Hebatic Encephalopathy Physician/ Medical Due to ir as a consequence of): Examiner Circhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated exacts.) Due to (or as a consequence of) Exami and -transit Hopalitis C that initiated events resulting in death) Last Due to (or as a consequence of) nding physician a use as the burial-1 Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 000 DECEMBER. 26,2010 MB,BS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSBITAL RAJEEV GUPTA, MBBS 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar

JAN 0 4 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ December 6:34 P Phillips Carlos Aquilar Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Harford 3402 Tulley's Point Ct. Apt. 2A Abingdon If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year. Country)
Mexico 1 🕱 M 2 🗆 F 1.938 72 Aug. Director 556-48-4975 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2X No Maryland Abingdon Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21009 USA 3402 Tulley's Pointe Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 1 XYes 2 ☐ No If Yes, Give Maryland 21215-0036 1 XYes 2 ☐ No Specify: Specify White 3 Widowed 4 Divorced Mexican Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Command Master Chief Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Florence Lillian Phillips Carlos Aquilar Palma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Aylwin Close, Newquay, Cornwall, UK Bronwen M. Phillips / Spouse Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp 1-5-11 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sunatur of Funeral Service Licenses McComas funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Strake Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last ت المادية المادية المادية المادية المادية و المادية و المادية Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 🗌 No g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director; After this certificate has been 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 \square Pending 1 🔀 Natural work?
1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 28/10 row) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12+1 103 Ba Reeser Ó 31, Date filed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink, Ensure, All Copies Are Legible.
Amend 24a, 25&26 per med cert G911114/4/All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PATTON Month Dav Vear Physician/ HERBERT MHOL 1810 13 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Meritus Medical Center 8. Date of Birth (Month, Day, 12 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Funeral ^{Year)} 1928 1 🕅 M 2 🗆 F Maryland 577-30-0887 Director Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X☐ No Hagerstown MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21742 41 Harvard Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Specify: white If Yes Give 147-153 Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) laborer 0 8 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Blanc Viola Hagen permit. Page 1 and 2 should be find Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev John William Patton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Harvard Road Hagerstown, MD 21742 19a. Informant's Name/Relationship (Type, Print) Jean M. Patton/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signature of Euneral S State AAAttomy Board 655 W. Baltimore Street Sicensee ade 21201 Baltimore, MD23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Chron, c LVNG Diseas Physician Medical resulting in death) Due to (or as a consequence of): Examiner V1 8 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and hranic attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical and, omy of P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at id be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [출 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2**X** No 25. Was case referred to medical of Vital director, 26. Place of Death (Check only one) B B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗷 No 1x Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 1 🗌 Yes completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural injury 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ EATHA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 1100 Owens Road Apt 418 Oxon Hill Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Country) Maryland Months Days Hours Min. Month Day, Year) 220-58-9030 58 Director Nov Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County with the Maryland 10a, State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 United States 1100 Owens Road Apt 418 filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married "natural", or ş Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black Completed 3 ₩ Widowed 4 □ Divorced I Hygiene. other than "natur vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cook Nursing Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili.
Department of Health and Mental |
Important: If item 27 is marked of any injury or other traumatic eve ၉ Howell Prather Lucinda Sewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarksburg, MD 20871 Montaneze Prather/son 23751 Clarksmeade Drive Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 1/3/2011 Woodbine, Maryland Flinal any inj 21. Sign Are of Funeral Service Lice Going Homes Cremation Service P.O. Box 784 thomas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD23a. Part \ Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month 5 Other (specify) Pregnant at time of death signed by the a Yes 9 Unknown g Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2; has autopsy performed? death? 1 Yes 2 No certificate director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Be Hospital 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending death. 1 ☐ Yes 2 ☐ No n 24 hours after death le Funeral Director: A pleted filled in by the fu Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

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DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2010 11:45 AM Domingo Perez Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Day, Year) 1934 (Month, D 1 X M 2 □ F Months Days Hours Min. 267-29-2192 Cuba **Director** Dec Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10a. State traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 XYes 2 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Numbe 23a United States 13703 Modrad Way, Unit 13 20904 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Cuban White Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Marble & Tile Finisher 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be fill treent of Health and Mental rtant: If item 27 is marked မ Alejandrina Dieppa Antonio Perez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13005 Blue Valley Place Silver Spring, MD 20904 Nicholas Poulos/grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of Important: If it any injury or of once. ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 1/5/2011 Woodbine, Maryland 21. Signature of Funeral Service Lig Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): -transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death Yes 2 No g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Aortic Aneurysm 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Parkinson's Disease autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2X No မ 1 Tyes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Hospital or Attending 1 XNatural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотріете (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and tit December 31, 2010 D63579 s of person who completed cause of death (Item 23a) (Type, Print) Maria J. Tayaq 1500 Forest Glen Road Silver Spring, Maryland 20910

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 4

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29, 2010 December 12:10 AM Roslyn Pokras Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hill Haven Nursing Home Adelphi Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours June II. Months New York วี919 Director 073-12-0511 Usual Residence of Decedent fshow 10a. State 10b. County with the Maryland notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? and Mental Hygiene. Is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be I Funeral 20901 9509 Saginaw Street United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within Elementary/Seconday (0-12) Dental Office Dental Hygienist Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fanny (Unknown) Joseph Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 strent of Health a tant: If item 27 is jury or other trant. 9509 Saginaw Street, Silver Spring, Maryland 20901 Robert Pokras / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date cemetery, crematory or other place, 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State December 31, 4 Donation 5 Other (Specify) Bethesda, Maryland Montgomery Crematorium,Inc. 2010 . Signature of Funeral Service License Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a conse wence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should been 24a. Was an 24b. Were autopsy findings available nas prior to completion of cause of death?

1 Yes 2 No autopsy certificate 24 hours after death.
Funeral Director: After this certifical eted filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completed (Check the within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and #119 of offilier 29c. License number 29d. Date signed (Month, Day, Year) December 30, 2010 47867 ddress of person who completed cause of death (Item 23a) (Type, Print) 4701 Randolph Road # 216, Rockville, Maryland 20852-2257 M.D. Zuniga, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN U 4 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13:00 PM perember Za Medical 50 Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SULL - FOV 8. Date of Birth (Month, Day, Ye Age (In yrs. last birthday) ear If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 M 2 K Months Davs Hours Min. **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45 Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural" 3 Widowed 4 □ Divorced Year or Dates and Mental Hygiene.
s marked other than "natura umatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1.9 eller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Jamu-e 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date UV cemetery, crematory or other place) 4 Donation 5 ☐ Other (Specify) 21. Signature of Meral Prvice License 18434 22. Name and Address NEW 99 1232 Midvalle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural work? 5 Pending 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my actions death and place. Medical 29a. Certifier 2 [3 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) completed cause of death (Item 23a) (Type, Print) fense Hry, Crofton, une 2/11/4 222 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** atree 472-4 M 2010 December /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death County of Death Examiner eartland Ad e rince Georges Home 5. Social Security Number (In vrs. last birthday) If Under 1 If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Davs Hours Min. 1 M 2 101-18-6073 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Howlard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21044 Patuxent U5A Little Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 by 1 ☐Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event. College (1-4or 5+) Assistant Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Littlejohn 2231 C MD 21044 Columbia 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) Miami C22. Name and Address of F 21. Signature of Funeral Sprvice License 23a. Part 1 Fifte, they sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or leart failure. List only one cause on each lying. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, dary teach of to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeard lifector, page 2 should be detached for use as the burlansit ment. Due to (or Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🖪 No 2 No 1 ☐ Yes 1 ∐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ospital To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) 31. Date filed (Month 4 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 31^{Day} Physician/ Dec. 2010 Alverta Marie Richard 4:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Towson Gilchrist Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min (Month, Day, Year) 1 D M 2 Yrs **Director** 76 215-30-7049 Usual Residence of Decedent 28a-f show 10b. County 10a, State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified MDBaltimore Cockeysville 1 Yes 2 X No 10e Street and Number 0 10f, Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 300 International Circle 21030 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 XMarried Yes 2 X No filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. white "natural", Specify: Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Registered Nurse Nursing Be permit. Page 1 and 2 should be filed. Department of Health and Mental H-Important: If item 27 is monany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Bryant Jerome W. Affayroox, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2706 Lawson Rd., Fallston, MD 21047 Donna C. Danna/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ty Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Highview Memorial Park 1/4/11 Fallston, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Funeral Service Licen aryan Mildiany 23a. Part 1. Enter the disease, or complications that collised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or con resulting in death) Onset and Death Ph sician/ Parumonia week KS Medical Examiner Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Day 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by & inphysema, dysphagia, 1 ☐ Yes 2 🔭 No 3 ☐ Probably 4 ☐ Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an covening enterny disease has e 2 s autonsy page certificate Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 NOther (Specify) 175 Specify ျဉ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this of in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Cartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swite 4105 Galtimore MB 21201 Pute 701 Churry 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year SHIRLEY RHODES 0907 12 Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNIVELSITY MARYLAND MEDICAL CENTER BALTIMOLE CITY CO. TIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Ye June 2, 1 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 - M 2 X F Hours Director 220-58-1409 58 $\tilde{19}52$ Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2X No MD Anne Arundel Co. Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 500 Kent Circle 21060 United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or ş 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify 3 Widowed 4 Divorced Completed White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life, DO NOT use retired) during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) yrs Account Technician Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Rhodes Betty List 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other trainonce. Mrs. Donna Williams / Daughter Fern Place Middle River, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 3, 2011 Glen Burnie, MD Crematory 21. Signature of Funeral Se 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EREBRAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** END ARTERECTOM CAROTIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence on that the death certificate be executed Cause (Disease or linjury that initiated events been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

Yes 2, No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes 2 🗌 No Other: ည 1 Npatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director. After 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Sectifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title of certifie 29d. Date signed (Month. Day, Year 12/3/10 RESTOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIVERSITY MARYLAND MEDICHE CENTER DENVILLE MA MYRIZ A. 21 SOUTH A4 LI IMORE 31. Date filed (Mon State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Riley Bonnie Lee DECEMBER 6:15 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE AGNES HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 F (Month, Day, Year) ≥b. 13, Days Director 56 1954 Maryland 214-64-5936 Feb. Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖁 No Arbutus Maryland | Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1300 North Ave. Apt. United States 21227 within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner ò 1 Never Married 2 X Married <u>≲</u> Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) N/A Elementary/Seconday (0-12) Healthcare Assistant 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic eventone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Donahue Ruby Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Joseph Riley/ Husband 1300 North Ave. Apt. 2, Arbutus, Maryland 21227 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 g Atlantic Crematory,LL&Jan.2,2011 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Signa ure of Funeral Service Lidensee 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death EREBROVASCULAR Physician ACCIDENT disease or condition resulting in death) 9 DAYS Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter University Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No Month Dav Vear 1 Yes 2 signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires VENTRICULAR THROMBUS Records, 1 Tes 2 No 3 Probably 4 M Unknown Completed NON-ISCHEMIC CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed' death? ALCOHOL ABUSE 2 🗌 No Yes 2 No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐XNo ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred Director: After 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Destroying Projection to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pranticions To the bost of my including could confine a stated. only one diat. The time, date and place, and due to the co 29b. Signature and title of certifier MEDICAL DOCTOR 714 D0069370 DECEMBER 30 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 KWAME NTIM S CATON AVE BALTIMORE MD 21229 31. Date filed (Month, Day, Year) State Darke **JAN 0 4** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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David William Roach

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	State of Maryland	d / Department of He	ealth and Mental Hyd	giene

	Registrar		Certifica	te of L	eatn			F	Reg. No.			
Physician/ Medical Examine	r	DAVID	WILLIA		ROACH 2. Date of Dea Month Decembe					ath Day Year er 21, 2010 3 Time of Death 0857 hrs		
	4a. Facility Name (if not institution 227 Lake Road	on, give street and number)			4b. City, Town, or Location of Death Pasadena					4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 47 Yrs. Months Days Hours Min. 7/26/1963											place (State or htry) MD
) any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							1	0d. Inside City Limits
ne Maryland or 28a-f show any fied at once,	MD Anne	Arundel	Pasad		0/ 7: 0 d				10 0'''			1 Yes 2 No
the Maryland or 28a-f sh tiffed at once	227 Lake Ro	ad			Of. Zip Code	21122	2		10g. Citizen			y?
t with t be not be not	11. Marital Status	12. Was Decedent	Ever in U.S. 1	13. Was D	ecedent of H	ispanic Origi	n? (Spec	cify Yes or N			merica	ın Indian, Black,
er death with t	1 Never Married 2 M 3 Widowed 4 Div	Armed Forces? 1 Yes 2 vorced If Yes, Give Year	X No		specify Cuba		Puerto Ri	can, etc.)	80	White, e		T71-
ours after a stural caming	45.5	or Dates:		ecedent's	Usual Occupa	ation (Give ki				ecify: d of Busin		White dustry
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Filem 27 is marked other than "natural", or items 23s or 28s-f short renumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4 or 5	(+)		of working life		ise retired	1)	Tr	uck	ing	
215-00; be filed withintal Hygiene, rked other thent, the Med			Doole					irst, Middle,		,		7:17:-
2121. 2121. d Mental H s marked tic event, I		David C		Mailing A	ddress (Stre	et and Numb	er or Rur	al Route Nu	ontgo mber, City o	or Town, {	y w State, Z	Villis Cip Code)
re, MD 2121; I and 2 should be fil. Fleath and Mental H fitem 27 is marked or traumatic event, I TO Be	David C. Roa	ich - fathe			ake R			ena,		2112		
Baltimore, MI pernit. Pages and 2 s Department of Health a Important: If iten 27 injury or other traum.	20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal from Sta		or other	place)			Date			•	own, State
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Physician //Medical	23a. Poff. Enter the disease, or failure. List only one cause		the death. Do not e	enter the r	node of dying	, such as car	diac or re	espiratory ar	rest, shock,	or heart		Approximate Interval Between Onset and
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ted nasit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	c										
uted d ansit	events resulting in death) Last	Due to (or as a consect.	quence of):								1	
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit completed by Physician/Medical Ex.	X UNPENDED	AMENDED #23a	ı,ptI,II,	27pe	rME,G9	11,1/2	20/20)11,WS				
18760, rtificate be ing physic as the bur	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth	e of pregnancy	Fetal					23d. D	ate of deli	livery Day	/ Year
O. Box 687 at the death certific the by the attending I mached for use as the Physician!	1 Yes 2 No 9 Uni	Pregnant at t	ime of death 5	-	(Specify)							
O. Boat the de	Part II. Other significant condit	and the second second	but not resulting in	the unde	erlying cause	given in Part	t.	23e. Did to	obacco use	contribut	e to the	cause of death?
S, P.O uires that t n signed by d be detac	Chronic alcol	hol use, Cirr	hosis of	the	<u>liver</u>	, Dila	ated	1 Ye	s 2 N	3 🔲 1	Probab	oly 4 🗸 Unknown
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Vital Recysician: The label bis certificate bidirector, page	25. Was case referred to medical				00.01-	(D . 1) . (0	· · · · · ·	1 ✓ Yes	2 No		Yes	2 No
of Vital ig Physician: fler this certifi neral director, 1: To Be (examiner? 1 Yes 2 No	Hospital: 1 Inpatien	t 2 ER/Outp	atient 3		Other			Residence	6 🗸 C	ther: S	cene
Division of Vital Records, tal or Attending Physician: The law requirers after death al Director. After this certificate has been sited in by the funeral director, page 2 should bertification: To Be Completed	27. Manner of Death	28a. Date of Injury (Month, Day,Ye	y 28b. Tim	e of Injur	· 1	ry at Work?	- 1	d. Describe	how injury o	ccurred		
Division or spiral or Attending tours after death serial Director: Aft filled in by the fune Certification:	2 Accident Inves	stigation 28a Place of Init	ıry - At home, farm	street fa		Yes 2 N		f Location (Street and N	Number o	r Rural	Route Number, City
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Division To the Hospital or Attent within 24 hours after death within 24 hours after death completely filled in by the Medical Certificati		nysician: To the best of my miner:On the basis of exam										ause(s)
To with	29b. Signature and title of certifie	and manner stated.	_		29c. Licens	e number			29d. Date	signed ((Month,	, Day, Year)
	D-MUL				O.C.	M.E.			Decem	ber 22,	, 2010)
81	30. Name and address of person Donna M. Vincenti, Mi	· ·		111 Pa	enn Street	Baltimor	e. MD 1	21201				
State			s Signature	0		,	-,					
Registrar	JAN 0 4	2011 Denus	p. 19	ank								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 30, 2010 6:05 A. M REDDING ALLAYNE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17203 WESLEY CHAPEL MONKTON BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Yea 11/8/1933 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours MARYLAND **Director** 212-30-1254 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 Yes 2 XNo PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8543 WILLOW OAK ROAD 21234 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 ₩ Widowed 4 Divorced Specify: WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 10TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JAMES A. DELAUNEY ARLINE V. FARLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCOTT REDDING/SON 211 HITCHING POST DR. BELAIR, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
DULANEY VALLEY MEM. 4 Donation 5 Other (Specify) 1/3/2011 COCKEYSVILLE CARDENS
22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Signa re of Funeral Service Li ensee MO1139 TOWSON, MD 8521 LOCH RAVEN BLVD. 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Carcinoma Ph sician/ -ung disease or condition Medical resulting in death) Due to (or as a nsequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) ii any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 2 🗆 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 SON'S RESIDENCE Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 24 hours after death. Funeral Director; After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 🗆 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)
DF7-8-7-3
December 38,2016

Chanles Towson, Manyland 21204 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manshill A. Levine, U569WINH 2. Registrar's Sign State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16b,17 Per FH &23e Per PHY G911 1/07 /2011 JH State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 Day Dec. Physician/ Edward Calvin Shepherd 2010 JOO PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Essex 1106 Oak Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. 18,1928 1 🔀 M 2 🗆 F Months Days Hours Min. 242-36-4858 Director 82 NC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any niury or other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21221 1106 Oak Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Products Elementary/Seconday (0-12) College (1-4 or 5+) Air Prodects Chemical Operator 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) M. Shepherd M. Shephard ဂ္ Gideon Gidean Rose Jane Osborne 19a. Informant's Name/Relationship (Type, Print)

Michael Sneperd /son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 Oak Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery, crematory or other place)
HOLLY Hill Cemetery 1/4/11 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Name and Address of Facility 300 Mace Ave, Balto, MD Connelly Funeral Home of Essex 21221 Hadron 23a. Part 1. Enter the disease, occur plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner a the Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year i signed by the ail Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an i 24 hours after death.

e Funeral Director: After this certificate has the Funeral director, page 2 s autopsy performed? 2 -25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 \square Pending Accident
Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059189 1-3-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopking Rayvin Circle 5 505 ns 21 31. Date filed (Month, Day, Year) 32. egistrar's Signature State JAN Registrar round

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:55 PM Thomas A. Sisk Dec 8 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Rosedale Damien Court 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗶 M 2 🗆 F Months Days Hours Min. Oct . 25 , 1956 54 216-72-2960 **Director** MD Usual Residence of Decedent show 10a State 10c. City, Town or Location nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant If item 27 is marked other than "natural", or items 23a or 28a-f shoinjury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore Rosedale MD 1 Yes 2 XNo 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 21237 USA 1 Damien Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 XYes 2 No Black, White, etc. 1X Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Tech AAT 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas P. Sisk Carol Anne Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Sisk /brother 614 Fuselage Avenue Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl cemetery, crematory or other place)

Bayview Crematory 1 Burial 2 XCremation 3 Removal from State 12/29/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave, Balto. 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between rockal IV Immediate Cause (Final Onset and Death Physician/ year disease or condition Medical Examiner resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): iding physician and se as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Tes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🔲 Yes 2 No Accident Investigation 24 hours after deatle Funeral Director: filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🚾 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101E

32. Redistrar's Signature

Trac, M.D

2200

346

Baltimore

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year 0515 AM ecembe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Memoria Pita Baltimore Social Security Number If Under 1 Year Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 M 2 F 218-18-4192 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore 1 Yes 2 □ No MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code rentuboa 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Yes 2 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/S onday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle. မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) areat nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jundalk, ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition Preumenie Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and de detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 autopsy performed? 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direc 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier

J. Kowatchow, MD 29c. License number **563748** 29d. Date signed (Month, Day, Year) december, 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorical Hospital, Baltimore, Maryland Joselfne Kougetcheu 31. Date filed (Mo Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician/ 340 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral (Month, Day, 1 DM 2 D F Months Hours Min. 87 Hawaii Director 575-16-3321 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medic | Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 XNo Maryland Harford Joppatowne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 311 Summerfield Ct. 21085 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Japanese Completed Year or Dates 16a Decedent's Usual Occupation 16b Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Tax Consultant U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) and Mental မ Taka (nmn) Maeda Tamejiro (nmn) Tanaka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is 1 any injury or other traumonce. 311 Summerfield Ct., Joppatowne, MD 21085 Kent Stapleton / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 12-30-10 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee ²² Name and Address of Facility
McComas Funeral Home,
1317 Cokesbury Rd., A Abingdon. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hours Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transil Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 X No Certificate: To 1 Tes 1 Inpatient 2 KER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No Natural Accident 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning in a stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 861629563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Baltimore in 1 GREENE ate filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month RINE 0955 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mov | 4, 1918 9. Birthplace (State or Foreign **Funeral** 1 \(\text{M } 2 New York Director 132-10-6608 92 Usual Residence of Decedent or 28a-f shov of Health and Mental Hygiene. item 23a or 28a-f shor item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2√ No MD Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? Funeral 2506 N. Haven Cove 21401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 🔀 No Specify: Specify: white Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked Frederick Traeger Agusuta Ullrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Sloan/daughter 115 Patricia Avenue Linthicum, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signature of Funeral Service Ronal of State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Pax J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final set and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, cate has been signated page 2 should b 3 Probably 4 Unknown Completed 1 Yes Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 2 N death? 2 🗌 No Division of Vital the funeral director, Be Was case referred to medical 26. Place of Death (Check only one) 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b Signature and title of certif er 234010 alan o completed cause of death (Item 23a) (Type, Print) Name and address of person 32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9.5327 M DELEMBER 12 ANTHONY JOHN SAROKA, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death c. County of Deat ASHINGTON MEDICAL CIRM THINE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Hours Country) 26 9773 88 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Anne Arundel 1 🗌 Yes 2 🌠 No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7733 West Shore Road 21122 U.S.A 12. Was Decedent Ever in U.S. Argued Forces?

1 🖾 Yes 2 🗆 No 194
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married "natural", or 2 No 1941 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Completed 1943 Year or Dates White 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Zoo Keeper Baltimore City Zoo Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony John Saroka, Sr Mary Kozier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Nash - Sister 7733 West Shore Rd. Pasadena, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem Gdn 12/28/10 Mariottsville, 21. Signature of uneral Service Licensee GJ Gonce Funeral Home Pasadena, 169 Riviera Drive 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ LIA disease or condition resulting in death) Medical e to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician ar as the burial-t Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 🗌 No Division of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation 2 🗆 No 6 Could not be Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar

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drive

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASA TO 301 Hospital Wille

31. Date filed (Month, Day, Year)

Hospital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	-	Certificate of			Reg. No.	UIU	41524			
	Physicia	an	Decedent's Name (First, Middle, La.	st)	CAUT			2. Date of De Month	Day	Year	3. Time of Death			
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<i>></i>	Examin	er	St. Joseph's Nur				consville		imore					
327.7	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last birtho									
	Director		216-16-6844	□M 2☑F	88 Yrs	s. Months Days	Trous IVIII.	April :			MD			
-	w w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				1	0d. Inside City Limits			
la de	f sho	lo	Maryland Talbo	o.t			Easton				1 ∐Yes 2 ဩNo			
4	r 28a- notif	Director	10e. Street and Number			10f. Zip Code	<u> </u>		10g. Citize	en of What Cour	ntry?			
1	23a o St be		29744 Charles Dr	ive			21601			US	A			
0	er my	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	 Was Decedent of F If Yes, specify Cub 	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	D- 1/	 Race - Americ Black, White, 				
3	be lied within 7 z nous arer death with the maryland tall Hygina tall Hygina do ther than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☑ No	Specify:			Specify:	White			
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212 2 2	al Hygiene. s other than "natu	Completed	(Specify only highest gra	de completed) College (1-4or 5-	+) (G	Give kind of work done fe. DO NOT use retired	during most of work d)	cing						
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land		Be	17. Father's Name (First, Middle, Last,				18. Mother's Nam	, , , , , , , , , , , , , , , , , , , ,		,				
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ē, §	ges lar t of Hea if Item or other	1	20a. Method of Disposition	.		isposition (Name of crematory or other place		Date		ation - City or To	own, State			
	rage nent c ant: if any or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			idge Cemet	1	2011	Elkr:	idge, Ma	ryland			
Baitimore,	permit. rages I a Department of He Important: If Item any injury or othe		21. Signature of Funeral Service Liger	ngee /		22. Name and Addre	-		_		lome, P.A.			
	20E # 9	9	Jan 2	27			ountain F			na, MD 2				
			23a. Part1. Enter the disease, or complications the daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final											
	hysician /Medical		disease or condition resulting in death)		consequence of)	-					TOAYS			
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9	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of)									
δŪ,	icate be executed physician and s the burial-transit	al E												
6876U,	g physician and as the burial-transit	edical	d											
			IF FEMALE: 23c. If yes, outcome pf pregnancy							23d. Date of delivery				
מ מ	e atte	sicia	in the past 12 pronths? 1 □ Yes 2 No	n the past 12 ponths? ☐ Yes 2 No ☐ Under the pregnant at time of death ☐ Other (specify)						Month Day Year				
7 j	w requires first the destricts been signed by the attendin should be detached for use	Physician/N	9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use or								he cause of death?			
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		Be Co	25. Was case referred to medical				26. Place of Dea		/	1 ∐ Yes	2 □ No			
> 1	nysici nis cer direc	To B	examiner? 1 Tes 2 Tho	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outp	atient 3 DOA Oth	ner: 4 Nursing H	ome 5□Res	idence 6	□Other (Specia	(y)			
חסר	rig rig		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		ıry Wo		28d. Describe			-			
SIO	tor: A	cati	2 Accident investigation 3 Suicide 6 Could not b		n. At home form		Yes 2 □ No	OOL Leastion	(Ct	d Marshau and Danie	at Davida Alembau			
DIVISION	after of Direction by	Certification:	4 Homicide determined	building, etc	: (Specify)	, street, factory, office			own, State)		al Route Number,			
- 1	to the nospinal or Attending raystrain; within 24 hours after death. To the Fuhrarai Director After this certifica completely filled in by the funeral director, I		(Check only 2 Medical Example 12	nysiclan: To the best of miner: On the basis of	examination and/									
4	thin 2	Medical	29b. Signature and title of certifier	and manner sta	ted.	29c. Licens			29d. Date	e signed (Month,	Day, Year)			
)	- 3 - 8		1. Satural	mo		Do	100400	7	DEC	EMBER 3	30, 2016			
	HV		30. Name and address of person who	completed cause of de		(pe, Print) ROAD SC	IN DOL	1, CATO	יונטור	JE; M!	0 0,009			
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	(1				
	Registr	ar	JAN 0 4 2011	General &	back	1								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death D. Month Day Physician/ 9-007M William Stroh Herman Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) ug. 08 1928 1 😡 M 2 🗆 F 214-24-7121 Director 82 Aug. Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 200 Southwood Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Stroh Fredericka Rossman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Southwood Road, Pasadena, Nancy S. Stroh (spouse) MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town. State cemetery, crematory or other place, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 05 Jan. Cedar Hill Cemetery Brooklyn, Maryland 4 Donation 5 Other (Specify) 2011 21. Signature Funeral Sel 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the dis ase, or comp ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final m mon Physician disease or condition Medical resulting in death) Examiner Scue tielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the a 9 Unknown Division of Vital Records, P.O. been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 000 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed 2 100 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tes 2 No Other: 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one d title of certifier 29b. Signature a

Registrar

State

30. Name and addre

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acities

ise of death (Item 23a) (Type, Print)

32. Registrar's Signaty

Amend 20b, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 24,2010 ear **Physician** December 14:34 M Smith Eden Elizabeth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Baltimore 2601 Huntington Avenue Birthplace (State or Foreign Country)
 MD 8. Date of Birth Dec. 30, 1944 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F 65 Yrs. Director 217**-**46**-**1703 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 'natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be modified at 1 Yes 2 No Director Baltimore MD Baltimore City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21211 2601 Huntington Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 3altimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Library Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucille Preston Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2245 Elou Street Wahiawa, HI 96786 Mr Scott Smith Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State January Mt.01ivet 8,2010 2011 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Service Licensee Services PA 1 2nd Ave.SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATHEROSCIENTIC Cordieusula diccise disease or condition resulting in death) /Medical Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner pate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of deeth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manuar of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2011 120059056 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 702 40th Street Best MD West 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 20: 26 PM Seboda December 28 Caro1 Ann 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Agnes If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y)
Feb. 21, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖺 F Months Days Hours 69 1941 217-38-3725 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Wedical Examinant to Item once. 1 □Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2412 21228 Harborwood Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Bernard Okonski Helen Katherine Malinowski ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl F. Seboda-2412 Harborwood Road, Catonsville Maryland, 21228 Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory Dec.30,2010 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signar re of Fineral Service Licensee Ambrose Funeral Home Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate support of the disease of the disease of the death of the disease of the di Approximate Interval Between Onset and Death gastric Immediate Cause (Final adenocarcinoma Physician one year disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Dun'tu (or as a consequence of) d any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Se boda, carus IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 □ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Bei Wang

State Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wang

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SIDNEY H. SMITH, JR. DECEMBER ' 2010 11:55 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NOTTINGHAM BALTIMORE **17** ARLEN ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) IL Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ★ M 2 🗆 F /Month, Day, Yes **Director** Yrs <u>334-01-7624</u> 90 Usual Residence of Decedent show . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It ath: If item 27 is marked other than "natural", or items 23a or 28a-f sho inty or other traumatic event, the Medical Examiner must be notified at, inty or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 Yes 2 X No NOTTINGHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 17 ARLEN ROAD USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 2 No 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE If Yes, Give 3 X Widowed 4 Divorced WWII Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MANUFACTURING SALESPERSON YEARS Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SIDNEY H. SMITH, SR. MARGARET FISHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14141 SUNNBROOK RD. PHOENIX, MD 21131 DIANA LEE JANNEY/DAUGHTER PHOENIX, MD21131 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s
Department of IImportant: If ite
any injury or ot
once. Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) METRO CREMATORY, INC. 4 ☐ Donation 5 ☐ Other (Specify) 1/3/2011 CATONSVILLE, 21. Signature of Funeral Service Licensee MO 1/139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Severe disease or condition 0 485 Medical resulting in death) Due to (or as a consequence of) **Examiner** 5413 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? page 2 should be detached for Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 🗆 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗍 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 24 hours after death ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the only one) 29b. Signature and title of certifier 2010

DHMH 17 Rev 7/2009

State Registrar

altimore, MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Padgettill, 560/ Loch Raven Blod

32. Registrar's Signatur

Padgett MD

State

Registrar

ROBERT MARK KAISER, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#ME 91750

DECEMBER 23, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER^D30, 2010 9:58 PM MIRIAM SPIELDOCK Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death BALTIMORE 600 SUDBROOK ROAD BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Days Hours 0476471916 94 Director 215-09-2612 MD Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 600 SUDBROOK ROAD USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No ☐ Yes 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: WHITE marked other than "natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other tha any Injury or other traumatic event, the N **PHOTOGRAPHER PHOTOGRAPHY** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ **ABRAHAM** FORD **LENA** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 STARHILL LANE, CATONSVILLE, MD DIANE WHYMS/FRIEND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State OHEB SHALOM MEM. PK. 01/02/2011 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD Signature June al Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown detached P.O. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 🗌 Yes 2 No or Attending Physician: 25. Was case referred to medical **Division of Vital** the funeral director, Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the form Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 address of person who completed cause of death (Item 23a) (Type, Print) WARMINGON BUR RAYMONE A. WIN STOW

DHMH 17 Rev 7/2009

State

Registrar

and

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 40 Month Day Year Physician SARACEND December 29,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Loch Raven V.A. Baltimore 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 216-50-4457 63 Sept 13,1947 Md. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show Wermast be notified at Md. Baltimore Eastwood 1 □Yes 2X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 7146 Eastbrook Ave. 21224 USA 23a Funeral items ? 12. Was Decedent Ever in U.S. Acmed Forces? 1 A Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 □Yes 2X No White Specify. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, it is Medical Exerci-Specify. <u>Ş</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs Mailman Post Office 2 yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dominic Saraceno Anna Stevenson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Saraceno wife 7146 Eastbrooke Ave, Baltimore Md. 21224 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. 1 Burial 2 □ Cremation 3 □ Removal from State Rosedale Md. Gardens of Faith 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222 21. Si mature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ark inson disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the irector, page 2 st autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: (Î No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Peath . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mayner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 29, 2010 Balto . Ad 3900 Loch Raven Blud. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S HEIDER

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jimmy Dalton Tolbert 7:52 PM Dec 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 109 Glider Drive Middle River Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day

July 1 Funeral 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 1954 1 KM 2 - F 214-58-8722 56 Director MD Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Middle River MD 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 109 Glider Drive 21220 12. Was Decedent Ever in U.S. Armed Forces? 1 ₭ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)
Planning Department (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) MArtin's 12th Be . Mother's Name (First, Middle, Maiden Surname)
MAybelle Stroud 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be fill tment of Health and Mental rant: If item 27 is marked Warren Tolbert iling Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 9 Glider Drive Baltimore MD 21220 19a. Informant's Name/Relationship (Type, Print) Maybelle Tolbert /mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott or other place 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 12/28/10 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Signature of Fune at Service Licenses Balto. 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Connelly Funeral Home of Essex 21221 **Approximate** Interval Between Immediate Cause (Final Onset and Death Physician/ -hroni2 disease or condition VERTS Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Doe to for as a consequence of if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death ō in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be detent 23e. Did tobacco use contribute to the cause of death? à 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation the within 24 hours after deal To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00035363

State Registrar strar's Signature

enera

Center 10 N. Greene St. Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marshall MD

4

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HORNE 500 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, **Examiner** owai Date of Birth ge (In yrs. 9. Birthplace **Funeral** ar Foreign 83 Months 1 □ M 2 🗹 Country) Director 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside Çity Limits Directo 1 Yes 2 No 10g. Citizen of What Country Funeral Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes a Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) e Be 17. Father's Name (First, Middle, မ 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Numbe eslie 30 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Olumbia 4 Donation 5 Other (Specify) Signature of Funeral Service Lidenses 51<u>51</u> tomore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months Ectopic pregnancy Month 5 Other (specify) cate has been signed by the page 2 should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 🗌 Yes 2 No 3 Probably Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform 2 No 1 🗌 Yes Division of Vital director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 110 Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify funeral Certificate: 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director. After completed filled in by the funer. 1 Watural 5 \square Pending work? 1 🗌 Yes 2 🔲 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cau

DHMH 17 Rev 7/2009

pf death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ Robert Towles Deumber 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DePaul House 3300 Benson Avenue Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral May 19, 1935 1 X M 2 □ F Min. Months Hours 219-32-5989 75 Marvland Director Usual Residence of Decedent show 10a. State 10b County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 3300 Benson AVenue, Apt. 224 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces? Black White etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Press Operator Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Robert O. Towles Sophia Kirsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Critenden - Daughter 973 Regina Drive., Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Loudon Park Cemetery 1-4-2011 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, MD Signature of Functal Serv 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Colon Cancer Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) that the death certificate be executed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 24 hours after death.

Funeral Director; After this certific eted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 2 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completed fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSKajapalnem D DOUS 7465 1/2/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N-5. RURPAKS (MD) 2835 S m1

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

ORIGINAL

32. Registrar's Signature

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28355minh Av. S-203-Baltimore, ND. 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ December 24, 2010 10:13 P M Tucker Albert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Gaithersburg 119 Church Gate Lane Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F Funeral Months Days Hours Min. June 26, Year 1946 District of Columbia Director 212-52-0443 64 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director Maryland 1 X Yes 2 ☐ No Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States Funeral 20878 119 Church Gate Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates. 1965-1969 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Industry Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Philip N. Tucker Hilda G. Holzheidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert P. Tucker / Brother 207 Cedar Lane Waterville, Ohio 43566 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, January 6, ō 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2011 Rockville, Maryland Parklawn Memorial Park 21. Signature of F meral Service Consee Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 LU MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Uremia Medical Due to (or as a consequence of): Examiner 2 Years Diabetes Sequentially list conditions, if any, leading to in neclute cause. Enter Underlying Examiner Due to for as a consecuence of attending physician and for use as the burial-transit 3 Years executed Cause (Disease or linjury Pancreatitis that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Yes signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Colon Cancer Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension after death.

Director: After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 🛂 No Other: ျ 5 Kesidence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29b. Signature a d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D December 27, 2010 D07162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 Shady Grove Road, Rockville, Maryland 20850 Martin W. Graf M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 4 2011 Registrar

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Otate of Me	ai yiai ia 7	•	tificate of D			Reg. No.			
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	Examin	er	4a. Facility Name (if not institution,				4b. City, Town, or Location of Death 4c. County of Death					.	
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	or 28	흐	10e. Street and Number	IMORE	TIKE	DVIL	10f. Zip Code			10g. Citizen	of What Count	ry?	
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39	je 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Marri 3 🕅 Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 🔀 I If Yes, Give Year or Dates.	No	1	☐ Yes 2 No	Specify:		Spe	ecify: WHIT	e. E	
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ore	ge 1 ar nt of H∈ : If iter or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. Place o	of Dispos ery, crem	sition (Name of natory or other place	9)	Date	20c. Locat	ion - City or Tov	wn, State	
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Ba	permit. Page Department of Important; If any injury or once.		21. Signature of Funeral Service Li	atta		- 10	Name and Addres	50.	L LEVINS ROAD, PI	ON & KESVI	BROS., LLE, MD	INC. 21208	
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<u>o</u>	ding F h. After funer	ate	1 Natural 5 ☐ Pending			Time of injury	28c. Injury work M 1 \square		28d. Describe h	ow injury oc	ccurred		
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$\frac{1}{2}$	tal or		4 El Hollioldo dotolili	building, etc	:. (Specify)				City or Tow	n, State)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check 2 Medical Ex	Physician: To the best of xaminer: On the basis of ex	kamination and/	or investi	igation, in my opinic	n, death occurred a	at the time, date a	nd place, and	d due to the cau	se(s) and manner stated.	
	o the	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	best of my know	vieage, a	29 c. License	number		29d. Date si	igned (Month, D	Day, Year)	
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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To the within To the comp	2	29b. Signature and				*	29c. Licens			9d. Date	signed (Month	n, Day, Year)		
		1	M			- 00 \ /=	Dist.	6113			12-3	1-10		
		30. Name and addres	A GAN	npleted cause of	Geath (Iten	п 23a) (Туре И D ,	7601	SLER	DR., TO	dws	san,	MD 2/204		
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** December 28, 2010 10:22 A M Patricia Viera /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9831 Lake Shore Drive Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea March 29, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1□M 2 F 576-74-0662 1958 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Immortant: If time 27 is ansked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Model Errorian rough or notified any 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1K Yes 2 □No Montgomery Village |Maryland| Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20886 United States 9831 Lake Shore Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 覧 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: White 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Director Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gabriel Viera Patricia Dunham ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Foley / Sister 9751 Highwater Court Burke, Virginia 22015 Baltimore, Date 3, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 nent of h January 1 ☐ Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland Fineral Service 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Bethesda-ChevyChase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 Ille MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician Hyperlipidemia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
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2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D38457 December 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nakul Goyal, M 1. Date filed (Month, Day, Year) M.D. 3801 International Drive #211 Silver Spring, Maryland 20906 32. Registrar's Signature State 0 4 2011 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 🍴 Certificate of Death = State Registrar Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5:55 PM Physician/ DECEMPLER 2010 WEAVER JR 10015 FREDERICK Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE CENTER JOHNS HOPKINS BAYVIEW MEDICAL 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex ^(ear) 1954 Jan 24 Country) **Funeral** Months Days Hours MD 1 ☑ M 2 □ F 56 217-62-2624 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Francisco. 10c. City, Town or Location 10a. State Director 1 Yes 2 No Essex Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21221 903 Frankowitz Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 🔀 No If Yes, Give Š 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Belcan Corp Engineer 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rita Ramult Louis F. Weaver Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 129 Sipple Avenue Baltimore MD 21236 Louis F. Weaver III/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 12/31/10 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Signature Funeral Service Licenses Home of Essex 21221 Connelly Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition WEEKS PNEUMONIA Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown 1 X Yes cate has been sig Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical ours after death. eral Director: After this certifica filled in by the funeral director, I Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 X No X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury 27. Manner of Death Certificate: (Month, Day, Year) iniury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be determined To the Hospital within 24 hours a To the Funeral Completed filled 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Michael Sandr 27, 2010 DOLTOR MEDICAL DECEMBER RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE BALTIMORE MD 21224 4940 EASTERN HOPHINS BAYVIEW MEDICAL CENTER JOHNS MICHAEL SAUDER Registrar's Signatum 31. Date filed (Month, Day, Year) State went

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:30p M Charles W. Whistler Jr. Dec 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Essex Woodsmans Court Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Hours 212-30-6727 77 **Director** April4,1933 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at death with the Maryland Director MD Baltimore Essex 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21221 9 Woodsmans Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 XYes 2 No Black, White, etc 1 Never Married 2 Married ģ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Carriers I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) White Custom Truck Driver and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ည Charles W. Whistler Sr. Anna Sidail 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21221 Diane Whistler /wife Woodsmans Court Balto. MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 1/3/11 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore MD 5 Other (Specify) 4 🗀 Do 22. Name and Address of Facility 300 Mace Ave.Balto. MD Juneral Swice Licens e Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final stre Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minociate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria /Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy page 2 performe death? certificate 1 Yes 2 No 25. Was case referred to medica director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: After 1 Natural work? injury 5 Pending 2 No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu death. Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who comp eted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

ORIGINAL

10-09987 Chaki Tyreek Wil	sor	Please Type or Print in Black Indelible Ink. Ensure All Copi State of Maryland / Department of Health and Mental F		gible.	1 151
Ollan Tyrook VIII		1- For State Certificate of Death		eg. No.	7 -1 0 4
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last)	Date of Deat Month	th	3. Time of Death
Medical Examin	ıer	Chaki Tyreek Wilson	December		1320 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deal 4406 Falls Road, Apt. 1 Baltimore	ith	4c. County of Deatl	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi	Irs. 8. Date of Birt	th(MM/DD/YYYY) 9. Bir	tholace (State or
Director	- 1	39-1011 12M 2□F 17 Yrs. Months Days Hours Mi		Foreig	
	H	Usual Residence of Decedent	July 17	7 1975	"110
7	ſ	10a, State 10b. County 10c. City, Town or Location	* = *		10d. Inside City Limits
Maryland 28a-f show	ğ	MD NA Baltimore			1 Yes 2 No
or 28%	Director	10e. Street and Number		og. Citizen of What Cou	ntry?
		4406 Falls Rd. Apt. 2/211 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (\$		SA 14. Race - Amer	ican Indian, Black,
eath w	Funeral	Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puert		White, etc.	, , , , , , , ,
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215 be file ntal H rked c	8	Joseph C. Williams Taya S.	Goods	son .	
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MD and 2 shc salth and 2 shc salth and 27 is	-	Toya S. Goodson - mother 4406 Falls Rd. Ap	Date	20c. Location - City or	* *
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Ba perm Depa Impo injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility	eral Home	o. Mo 2122	9
Physician	\dashv	23a, Part Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Alcohol and Narcotic (Methadone) Int	toxicatio	on	Death
_Adminier		or condition resulting in death) Due to (or as a consequence of):			
	۵	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
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xecuted n and - transit		events resulting in death) Last Due to (or as a consequence of): d.			
• स्त्र •	<u>8</u>	M UNPENDED AMENDEDITEM 23a, 27,28a-f per ME 1/18	/11 G911	eg	
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician proprietry filled in by the funeral director, page 2 should be detached for use as the burial		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	<u>, </u>
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Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the form	Series -	Suicide 4 Homicide 6 K Could not be determined (Specify) Residence	or Town, St Baltimor	treet and Number of Ru ate) 4406 Fall e. MD 2121	ls Rd. Aptī I
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To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a		
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,		/ Kerdone M. King The, in a //;	w (VIII)	December 27, 20	-
Ø		30. Name and address of person who completed lause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimor	re, MD 21201		
Sta	te	31. Date filed (Month, Day, Yew) 4 2311 32. Registrar's Signature			
Registr	ar	JAN V 4 2017 Census B. Barles			

WIGGINS, CARNETHA

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Baltimore,	f He item		20a. Method of Disposition 1 Burial 2 Cremation	•		20b. Pla	ce of Dispos	sition (Name of satory or other place		Date			City or To	
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Bal	permit Depar Impor any in once.		21. Signature of Funeral Service	Cur	1		22. M.	Name and Address arch F/	ss of Facility H West ash Av	ve, Balt	imo	ore,	Md :	21215
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-	Physician/		Immediate Cause (Final disease or condition	_ a	Seve		Metabe	dic Acie	dosis					Onset and Death
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	1		30. Name and address of person			death (Item 2				1 0		-		
			DR. JYOTI 31. Date filed (Month, Day, Year)	CHAUI	/	rar's Signatur	Simo	u Maspi	tal o	Baltin	200 M	e_		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 2010 MARK RICHARD WILLIAMS 10:12 P™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center @ GBMC Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. July 8. 1961 Mary Land Yrs. Director 49 218-76-701*4* Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 No PA York Fawn Grove 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 704 Bridgeton Road 17321 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 😾 Married 1 ☐ Yes 2 🔀 No If Yes, Give 72 hours after altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hyglene. is marked other than ' permit. Page 1 and 2 should be filed within. Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Auto Repair Adjuster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clara Marie Stiffler Ashton Owen Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Bridgeton Road, Fawn Grove, Pennsylvania 17321 Neva L. Williams / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 12-31-10 Joppa, Maryland Union Chapel U.M. Chr. 22. Name and Address of Facility
MCComas Funeral
1317 Cokesbury 21. Signature of Funeral Service License Home, P.A. Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complication what caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Caquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 \square No 1 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Magner of Dea 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and itle of certifier

700

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 20, Physician/ 2010 10:05 AM Bettie C. Wright Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Allegany** Egle Nursing Home Lonaconing 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1 🗆 M 2 😾 F Min Mary Land Yrs **Director** 212-12-8168 Sept Usual Residence of Decedent 10c. City, Town or Location 28a-f shov 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 Yes 2X No Lonaconing MD Allegany 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 57 Jackson Street 21539 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 1 ☐ Yes 2 X No If Yes, Give within 72 hours after altimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) medical secretary and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill of Health and Mental item 27 is marked Blanche Goldsborough ည Roy Clower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 172 Cottonwood Creek Lane Alken, SC 29803 Marcia McDonald/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) $^{22}_{\mbox{\scriptsize Name and Address of Facility}}_{\mbox{\scriptsize Name and Address of Board}}$ Board 655 W. Baltimore Street . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate erval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Minute. Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examir and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown g Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Choric obstructive pulmonary 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Consestive Heart 24a, Was an cate has by page 2 s performed? Yes 2 No 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗆 Yes 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 121188 tin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 32 Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 55 Per FH G912 2/03/2011 JH

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 4635 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, **Funeral** New York Months Hours Min. 048-40-6655 Director 62 1948 Usual Residence of Decedent or 28a-f show e notified at 10c. City, Town or Location 10d. Inside City Limits 10h County within 72 hours after death with the Maryland 10a. State Director Hartford CTFarmington 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a o Funeral 15 Girard Avenue 06032 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates than "natura" 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Commercial Dishware College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha traumatic event, the Business Owner Sanitizing Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harrison C. Warren Laura Grace Lesan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Leslie A. Warren / Wife 15 Girard Ave., Farmington, CT 06032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 12/30/2010 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between nset and Death Immediate Cause (Final disease or condition tasta Physician. Medical resulting in death) Due to (or as a consequence of) **Examiner** la Seque itially list cor ultions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last the burial physician Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Dav signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed' Hospital or Attending Physician: The 2 🗌 No 1 Yes Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral dir 욘 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Of D

Natural

Accid

S 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a or, 445 DEFENSE HWY FN ENTEUE U 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DE CEMBER Physician/ 08:35 AM Elmer Joseph Windle Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A SAINT AGNES HUSPITAL BALTIMOKE 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Mar. 9, Year) 923 Mary Land 1**XX**M 2 □ F 87 217-18-5870 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martial Hygiene.

Important: If fine 72 is marked other than "nature." 10a. State 10b. County 10c. City, Town or Location Director N/A Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21229 United States 766 Yale Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. <u>م</u> 1 Never Married 2 Married 2 🗌 No Navy 1 Yes 2 No Specify. Specify: If Yes, Give White Year or Dates. WWII Completed 3 XWidowed 4 Divorced 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive State of Maryland Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Elmer Charles Windle Gertrude McKenna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7793 Cox Point Court, Baltimore, MD 21226 John Windle - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State New Cathderal Cemetery 1/5/2011 Baltimore, MD 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final META-STATIC PROSTATE CANCER Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner YEARS ORONARY AKTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HYPERTENSION 1 Tes 2 No 3 Probably 4 Kunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE HEART FAILURE 24a. Was an autopsv perform 1 ☐ Yes 2 📉 No 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical **Division of Vital** filled in by the funeral director, Certificate: To Be WINDLE examiner?
1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA after death, Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pendina 1 Yes 2 🗋 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0070917 DECEMBER 28 2010 SUITE LLIO - 3455 WILKENS AVE BALTIMORE, MARYLAND 21229 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mont State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1.2 Physician/ 2010 11:30A^M Marjorie May Ward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Convalescent Center Crofton Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 XX Days Hours 89 Yrs Director 474-16-8444 Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland al Hygiene. other than "natural", or items 23a or 28a-f sho Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked ther than "natural", or items 23a or 28a-f sho ant: If item 27 is marked than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6506 S. Chapter Road USA Apt. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1xx Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ₩Widowed 4 □ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peter Ward Julie Johnson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 533 6th Street Pasadena, MD 21122 Mr. Peter Ward/ son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) 12/29/2010 Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation PA 1 2nd Ave. SW Glen Burnie, MD 21061 Services, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by memica 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 2 NO NO 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 TYes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After thi completed filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a d title of certifier 29d. Date signed (Month, Day, Year)

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State

Registrar

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Day, Year)

JAN U4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 ear 11:13 AM December Elizabeth McNeill Weeren 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) an. 10, 1921 1 □ M 2 🂢 F Months Days Hours Min. Canada 364-16-1105 89 Jan. Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location 1 Yes 2 X No Maryland Montgomery Potomac 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Apt. 207 20854 United States 9440 Newbridge Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black White etc. þ 1 Never Married 2 Married ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Counsel for the life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Aging Geriatric Care Specialist 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Edith Smith Hugh Hanna McNeill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret E. McCormick/Daughter 5419 Harwood Road, Bethesda, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) January 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland 4 Donation 5 Other (Specify) Montgomery Crematorium 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc M01173 7557 Wisconsin Avenue, Bethesda, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dauge on each line. Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic Heart Disease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, rany, leading to inimediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗓 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ∐ Yes 2 ½ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an 2X No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 💢 No 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify)

attending physician Completed by Physician/Medical the signed by has 24 hours after death Funeral Director:

Physician/

Medical

Examiner

Funeral

Director

or 28a-f shov

items 23a

5

"natural",

and Mental Hygiene. is marked other than

permit. Page 1 and 2 sin Department of Health an Important: If item 27 is n any injury or other conce.

Pnysician/

Medical

Examiner

executed

certificate be

or Attending Physician; The law requires that the death

Hospital

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To the I

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Records,

Division of Vital

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3

traumatic event,

Director

Funeral

Be

the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Be ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a 29d. Date signed (Month, Day, Year,

0055480

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20814 M.D. 8600 Old Georgetown Road, Bethesda, Maryland Brendan Carmody, 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 4 2011

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 1050 AM Wagle Ambika D. Decembe 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🛚 F Months Days Hours Min September 7, 1936 India 308-48-6377 74 **Director** Usual Residence of Decedent 23a or 28a-f shov 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10a. State traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 X No Virginia Fairfax Fairfax 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22033 India 12223 Harbor Town Circle 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Way le Ambi Ka Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Asian Indian 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Flementary/Seconday (0-12) Medicine Doctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Umabai Netravali Kashinath Kasbekar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12223 Harbor Town Circle, Fairfax, Virginia 22033 Shriniwas D. Wagle / Son or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 2, 1 🗌 Burial 2 ី Cremation 3 🗌 Removal from State Bethesda, Maryland Montgomery Crematorium, Inc 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fune | Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Medical resulting in death) Due to (or as a consequence of) **Examiner** hon ocourd. Sequentially list conditions, in any, leading to in reclate cause. Enter Underlying Examine Law to the as a consequence of as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death cate has been signed by the page 2 should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No certificate 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, i To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 410 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: ■ Natural 5 Pending M 1 Tyes 2 No 2 Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: Dn the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pockville, mD Medical Cor Dr Joel E MD 9901 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN U 4 2011 Registrar

1050

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middle, Las) Physician/ Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Dundalk 8168 Midhaven Road If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Numbe **Funeral** Days Months Hours 1**∑** M 2 □ F Maryland 213-66-9177 54 Director February Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is amarked other than "natural", or items 23a or 28a-f should may only or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Dundalk 1 Yes 2 XNo Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21222 8168 Midhaven Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. ò 1 X Never Married 2 Married 2 No ☐ Yes Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Local 1548 Millwright 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Hahn John Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8168 Midhaven Road, Dundalk, Maryland Sandra Strom Friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 3, 1 Burial 2 XCremation 3 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 2011 Baltimore, Maryland ^{22. Namme and Address of Facility}
Connelly Funeral Home Of Dundalk, P.,
7110 Sollers Point Road, Dundalk, Md 21. Signature of Funeral Service Liger 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and trar Due to (or as a consequence of). attending physician for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death signed by the a 9 I Inknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown Records, 2 No should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? Hospital Other: 1 🔲 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 🗌 Yes 2 🗌 No death. Investigation after death Accident the Accider
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the within To the 29c. License number 30. Name and address of person who co 31. Date filed (Month, Day, Year) 32. Registra State JAN 0 4 2011 Registrar

DHMH 17 Rev 7/2009

Amend #11, per Fh State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Addie Beatrice Williams DECEMBER 30 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. Coupty of Death Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 XF 261-44-2950 80 June 20. Director 1930 Georgia Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location ns 23a or 28a-f show 10d. Inside City Limits Maryland Harford Havre de Grace 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21078 USA 2201 Williams Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after di Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or item any injury or other traumatic event, Itan Puritical Evaning 1 1 Never Married 2 Married Specify: black 1 ☐ Yes 2 X No Specify. þ 3€ Widewed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hezzie Fedrick Essie Jenkins ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Williams / Husband 2201 Williams Dr, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gdns:01/5/2011 Aberdeen 4 Donation 5 Dother (Specify) 21. Signature of Fundat Service Licensee Tarring-Cargo Funeral Home, P.A. 333 S. Parke St., Aberdeen, MD 21001 sanly 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annroximate Onset and Death Immediate Cause (Final **Physician** Congetive resulting in death) /Medical Due to (or as a consequence of): Examiner pantenviron Sequentially list conditions, if any leading to impossible cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-tran and resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the ası attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. the 1 □Yes 2 □No. 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed peen cate has t , page 2 sl 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 10 No certificate | 1 □ Yes 1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, Year) 0 4 20 State 32. Registrar's Signature 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec 13. Verna L. Armstrong 10:35 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** (Month, Day, ug 10, Days Hours Director 383 38 2868 70 Arkansas Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits Maryland | Prince George's Upper Marlboro 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be with Funeral 23a 7505 Gambler Drive United States items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō Š 1 Never Married 2XX Married 1 Yes 2 Who If Yes, Give XX Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify "natural", 3 Widowed 4 Divorced Specify: Completed **Black** the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) it. Page 1 and 2 should be filed withinthent of Health and Mental Hygienn reant: If item 27 is marked other thingury or other traumatic event, the Secretary Covernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Aaron Walker UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan Armstrong (Son) 27 street, Davids Court, Stafford Virginia 22556 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or Lee Crematory 4 Donation 5 Other (Specify) Dec 18, 2010 Clinton, MD Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria M01553 Ferry Road Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably 4 honknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No After this certificate 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospita 2 No Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) I Director: After this ed in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 24 hours Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only one 🖟 🗆 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati 29c. License number Name and address of per of death (Item 23a) (Type, Print) 236

State Registrar 31. Date filed (Moni

Registrar's Signature

16a. Decedent's Usual Occupation

3. Time of Death

1:00 P. M

2010

United States

Specify: White

16b. Kind of Business/Industry

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

December 10, 2010

14. Race - American Indian. Black, White, etc

Prince George's

9. Birthplace (State or Foreign

North Carolina

10d. Inside City Limits

14 Yes 2 No

Completed

Pages 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. Permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once.

Baltimore, Maryland 21215-0036

death with the Maryland

Physician /Medical Examiner

attending physician and for use as the burial-trar ed by the a signe be (page 2 s

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Medical Certification: To s after death.

I Director: After this ed in by the funeral of completely filled in by To the .

To the Funeral D'

To the Funeral D' ろナ

2 Accident 3 Suicide

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a, Certifier

6 ☐ Could not be

DEC 15 ZUVO

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Brick Mason Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Henry Allman Elizabeth Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn E. Allman, Jr. -son 4805 Iroquois Street College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 12/14/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final META STATIC COTOM CLANCES disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events METERLY OLSEASE Exami COROMARY resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Registrar

State

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Steven Tee, M.D. 3415 Hamilton Street, #1 Hyattsville, Maryland 20782

32. Registrar's Signature

1 ☐ Yes 2 ☐ No

1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D46998

10-09340 Jamie J. Allan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 4554 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	e or Maryland / L	-	te of Dea		ila Melik	, ,	Reg. No.	
Physicia Medical Examir		Decedent's Name (First, Middle, L Jamie	James	···	Allan	-		2. Date of De		3 Time of Death 0318 hrs
		4a. Facility Name (if not institution,				y, Town,	or Location of		er 5, 2010 4c. County of	
		6334 1st Street				erdale		<u> </u>	Prince G	
Funeral Director		215 65 1255	Sex 7. Age (II	n yrs. last birth		nder 1 Ye			5/1982	9. Birthplace (State or Foreign
nnd show any nce,	'n	10a. State 10b. County	George's	c. City, Town o						10d Inside City Limits 1 Yes 2 X No
h the Maryla 3a or 28a-f	Director	10e. Street and Number 3428 Ephron	Circle		10f. 2	Zip Code 20	716		10g. Citizen of Wh Jamai	*
	r Funeral	11. Marital Status 1 X Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Decedent Eve Armed Forces? 1 Yes 2		If Yes, spe	cify Cuba		? (Specify Yes or Nuerto Rican, etc.)	14. Race White Specify:	- American Indian, Black, , etc. Black
ours af	ğ Q	15. Decedent's Education (Specify	or Dates:		ecedent's Usu	al Occup	ation (Give kin	d of work done	16b. Kind of Bus	
9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Completed	Elementary/Secondary (0-12) 1 2	College (1-4 or 5+)		uring most of w		anic	_		mobiles
215-1 oe filed ital Hyg ked oth	ğ B	17. Father's Name (First, Middle, La ROXY Allan	st)					Name (First, Middle ilda Da	Maiden Surname) Wkins	
D 21 should then and Men	P 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State) 2 Mitchell House Australia Rd. T.on								, State 74 p CodeEnglar	
and 2 sho and 2 sho fealth and item 27 is traumati	ŀ	20a. Method of Disposition	/Sister	20b. Place of	Disposition (N	ame of co	emetery.	Date		LondonW-12,
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If liten 27 is marked other ti		1 X Burial 2 Cremation 3 4 Donation 5 Other Special 21. Signature of Funeral Service Lice	fy:	Sümme	rfiel				ľ	ndon, Jamaica
Balt permit. Depart Import injury		Mel D Mus			PHILI 9241	P D	.RINAI	DI FUNE	RAL SER	VICE,P.A.
Physician /Medical		23a. Part I. Enter the disease, or con failure. List only one cause on	nplications that caused the each line.	death. Do not o	enter the mode	e of dying	, such as card	iac or respiratory ar	rest, shock, or hear	Approximate Interval Between Onset and
ixaminer	Little of the Country of Country of the board							Death .		
	Sequentially list conditions, if any, leading to immediate	ince of):	7):							
0	Cause. Enter Underlying Cause (Unsease or injury that initiated									
ecuted and and transit	Ĕ	events resulting in death) Last	d	nice or).						
760, cate be execute physician and the burial - tran	Medical	UNPENDED	AMENDED	•						
certifi	Physician/M	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of 1 Live birth 4 Pregnant at time	2	Fetal death		Ectopic pr	egnancy	23d. Date of d Month	elivery Day Year
that the de ned by the detached f		Part II. Other significant conditions	9 Onknown	not resulting in	n the underlyin	ng cause	given in Part I	23e. Did t	obacco use contrib	ute to the cause of death?
s, P.O.								1Ye	s 2 🗸 No 3	Probably 4 Unknown
Division of Vital Records, P.O. Box ral or Attending Physician: The law requires that the death rs after death. al Director: After this certificate has been signed by the atterled in by the funeral director, page 2 should be detached for unitification. To Be Commissional by the internal director, page 2 should be detached for unitification.	Сощріете			-	-			24a. Was auto perfo	osy pri orm <u>ed</u> ? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
tal Recipient The certificate rector, page		25. Was case referred to medical examiner?	Hospital:				of Death (Ch			
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sion (trendin death.	allor	1 Natural 5 Pending 2 Accident Investiga	Dec 5, 2010	0226 h	rs		Yes 2 ✓ No	Subject sho		
E E G D		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 4 Homicide 4 Homicide (Specify) Local Street 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 6334 1st Street, Riverdale, MD								
29 a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only one 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner as state on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as state on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as state on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as state on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as state on the basis of examination and/or investigation.							s stated e to the cause(s)			
F W S	2	9b. Signature and title of certifier	and manner stated		29	c. Licens	e number		29d. Date signed	(Month, Day, Year)
						December 5	, 2010			
	3	 Name and address of person who Zabiullah Ali, M.D. Ass 	completed cause of death istant Medical Exami		Penn Stree	et, Balt	imore, MD	21201		
Stat Registra		1. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	Way.					· · · · · · · · · · · · · · · · · · ·

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2010 BETTIE SHOCKLEY ALTFATHER 1508 M Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner KENT CHESTER RIVER HOSPITAL CENTER CHESTERTOWN Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Hours Months (Month, Day, 1 M 2 X Director 84 MARYLAND 220-26-8271 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 🗌 Yes 2 🕱 No MARYLAND QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1433 RUTHSBURG ROAD 21617 UNITED STATES iral", or items ! Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 0. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify. Specify: WHITE "natural", 3 ▼ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 **EDUCATION** TEACHER ed other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental Fitem 27 is marked o other traumatic eve ည CHARLES NORWOOD SHOCKLEY, SR. JULIA ELIZABETH CAREY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 587 CENTER DRIVE, SEVERNA PARK, MARYLAND, 21146 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th ELIZABETH MICHAEL/DAUGHTER Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State CHESAPEARE CREMATION DECEMBER 9, 1 Burial 2 Cremation 3 Removal from State STEVENSVILLE, MARYLAND 4 Donation 5 Other (Specify) CENTER 2010 Significant Service Licensee FEILOWS AND THELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ROGRESSIVE Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine ECURRENT Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical FIBRILL Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year the be detached 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? death? Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending after death. 1 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 12 10 DEX 30. Name and address of person who comp egistrar's Signatur -9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month ELIZABETH EVELYN BOWEN December 2010 10:40 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Hours Min 04-08-1922 Mary land Director 216-18-5629 88 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🏋 No MD Frederick New Market 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 5649 Boyers Mill Road 21774 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Midowed 4 □ Divorced Completed Specify: white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) . Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samue1 William Watson Birdie Mae Catterton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance M. Mudd, daughter 5649 Boyers Mill Rd., New Market, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 12-27-2010 Cheltenham, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death Herosch disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown the Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by neumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of performed? Yes 2 No death? eral Director; After this certificate filled in by the funeral director, page 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work ☐ Accident ☐ Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number

32. Registrar's Signature

Frederi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

31. Date filed (Month, Day,

MO 51610

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 12, 2010 Physician/ Linda BECKWITT 9:40 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth AU9^{nth, B}ars Year)1949 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 K I Prinois 61 Director 321-44-6246 ral", or items 23a or 28a-f show Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Bethesda Maryland Montgomery 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 United States 5212 Danbury Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Public Interest Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Philip Lewis Geraldine Lawanda 19a. Informant's Name/Relationship (Type, Print)
Daniel Beckwitt, Son 19b Mailing Address (Street and Number or Bural Route Number, City or Town State Zip Code) 5212 Danbury Road, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 12/15/10 Waldheim Cemetery Chicago, IL Porchitistes of ethrew Funeral Home 20012 <u> 254 Carroll St., NW, Washington, DC</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastatic Breast Cancer Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 1 ☐ Yes 2 ☒ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No after death.

Director: After this certificate ! 1 ☐ Yes 2 ☐ No upleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 XInpatient 2 ER/Outpatient 3 DOA 잍 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Tes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, December 12, 2010 D 62571 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

M.D.,

Sarah Bromeland, 31. Date filed (Month, Day, Year) 1500 Forest Glen Road, Silver Spring, MD

20910

Physician/ Medical Examiner

that the death certificate be executed

P.O. Box 68760

Records,

Division of Vital

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifications.

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Physician/

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within 72 hours after

Baltimore, Maryland 21215-0036

Physician/Medical To Be Completed by Certificate: thin 24 hours after death.

the Funeral Director: After minimulation of the function of the further of the furt

29b. Signature and title of certifier

HAMPTON CRIMM

DEC

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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USN

Registrar's Signature

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	shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused the death. Do not not cause on each line. METASTATIC BREAST	Approximate Interval Between Onset and Death					
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Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year				
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Comple		death?	autopsy findings available to completion of cause of 1? Yes 2 No					
25. Was case referred to medical examiner?								
욘	1 ☐ Yes 2 🔀 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Out	tpatient 3 DOA Other: 4 Nursing	ng Home 5 ☐ Residence 6 ☐ Other (Specify)				
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		ime of 28c. Injury at work? M 1 Yes 2 No	28d. Describe how injury occurred				
Medical Certificate:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medica	(Check 2 L Medical Exami	iner: On the basis of examination and/or	leath occured at the time, date and place, Investigation, in my opinion, death occurred edge, death occurred at the time, date and pl	at the time, date and place	e, and due to the	cause(s) and manner stated.		

RES-000

29d. Date signed (Month, Day, Year)

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

29c. License number

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Borys BOJARSKI Month 2:11 A December 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Yea Funeral Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 X M 2 □ F Hours Poland Director Yrs. 215-54-7585 87 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No <u> Marylandl Montgomery</u> Silver Spring ō 10g. Citizen of What Country? Funeral 417 East Indian Spring Drive 23a United States 20901 ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Baltimore, Maryland 21215-0036
per nit. Page 1 and 2 should be filed within 72 hours after dea
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or ite
any injury or other traumatic event, the Medical Examine Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 🌠 No Specify: Specify: white 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Optician</u> <u>Optical</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Bojarski Rachel (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Bojarski, Son 12600 Bridgeton Drive, Potomac, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Judean Memorial Gardens 12/15/10 22 Name and Address of Facility
Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiopulmonary Arrest disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Dus to (or as a consequence of). sician and burial-transit Aspiration Pneumonia that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Large Left Pleural Effusion IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Hospital or Attending Physician: **Director:** After this certificd in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: မ 1

Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number | Number 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

3

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

UEC 15 2010

Division of Vital Records,

Majid Rahmanian, M.D., 1500 Forest Glen Road, Silver Spring, MD

1 mani-

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 66372

29d. Date signed (Month, Day, Year)

12/13/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year Physician/ В Bowen Vi Ctoria Dec. 12, 7:40 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) WV 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) 1925 April 3 1 M 2 🗓 F Months Days Hours **Director** 405-24-0704 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5001 Aspen Hill Road 20853 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🗷 XNo Specify. and Mental Hygiene. is marked other than "natural", Specify:White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy, Important: If item 27 is marked any injury or other #= Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Jackson Christena Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judi Bruchey/Daughter 900 Golden Eye Court, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 18 Dec. Sate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, MD 21. Signature of Funeral Service Licenses 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, o con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only 1 ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Orderlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician a the for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown 1 ☐ Yes ∠ ∡ 9 ☐ Unknown signed by the Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? 2 Metabolic Acidosis, Primary Biliary Cirrhosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ၉ 1 🔲 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending thin 24 hours after death the Funeral Director: A impleted filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ় 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier spelistatus MD HD D59980 10 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD 20814

State Registrar 31. Date filed (Mor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2010 Year Physician/ William Jacob Bauer Dec . 12, 6:30 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Birthpiac Country) O<u>hio</u> Months Days Min June 9, 1943 Hours 276-40-5123 Yrs. Director 67 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏋 No MD Montgomery Silver Spring 5 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be Funeral 130 Eastmoor Drive 20901 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? 14. Race - American Indian, "natural", or iter edical Examiner Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify. White Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Ith and Mental Hygier 27 is marked other to traumatic event, the 4 Construction/Remodeling Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ Clarence J. Bauer Marie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracey L. Conway/Daughter 11107 Welsh Hill Road, Frostburg, MD 21532 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Dec. Metropolitan Crematory Alexandria, VA 2010 4 ☐ Donation 5 ☐ Other (Specify) Juneral Service Licensee _22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Encephalopathy Anoxic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Ventricular Fibrillation, Full Arrest Sequentially list conditions, Examine Due to for an a nonneguence of: cause. Enter Underlying Cause (Disease or iinjury that initiated events e attending physician and The law requires that the death certificate be executed Congestive Heart Failure Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Pulmonary Edema page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe nned: 2 1 10 1 🗌 Yes Yes ours after death. eral Director: After this certificalilled in by the funeral director, illed To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 2 No Other: 1 🔲 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending work 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier - peteldr 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 5 12/12/2010 reparrich. D 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) Registrar's Signature State 15 2010 Registrar DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene United For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . Day 2010 Physician/ Frances Wisnewski Bailey 10, 6:30 P M Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 5308 Carvel Road Bethesda If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 91 Days Hours Min 1 □ M 2 F 08/21/1919 177-12-3664 Pennsylvania **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Bethesda MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 20816 Funeral 5308 Carvel Road 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 No 1946 Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natur aumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Own Home <u>Homemaker</u> permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, th once. Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary Grotski 17. Father's Name (First, Middle, Last) ပ Thomas Wisnewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Bailey Thigpen / Daughter 5308 Carvel Road Bethesda, MD 20816 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ACremation 3 ☐ Removal from State cemetery, crematory or other place) 12/14/2010 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA National Crematory 22. Name and Address of Facility ${\sf Joseph~Gawler's~Sons~Inc.}$ 21. Signature of Fulleral Ser 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): y physician and as the burial-trees To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f g Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown been si should 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? certificate has performed? Yes 2 X No 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 XNo 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of confie 29c. License number 20

State

Registrar

5454 Wisconsin Ave., #925

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sean M. Dwyer MD

5 2010

31. Date filed (Month, Day, Year)

D25818

Chevy Chase, MD

12/13/2010

20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death BITCHE Physician/ Month Year 2347 M AVID Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mandrin Chesapeake House House Harwood Anne Arundel Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth **Funeral** Days 195-32-2278 69 7/27/1941 Pennsylvania Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Anne Arundel Annapolis 1 Tes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 531 Wood Duck Lane 21409 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify: 3 Divorced Year or Dates Page 1 and 2 should be filed within 72 hourment of Health and Mental Hygiene.
ant; If item 27 is marked other than "natulury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Public Relations Manager Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Leroy Bik1e Dorothy Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matilda Young/Wife 531 Wood Duck Lane, Annapolis, MD 21409 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 12/14/2010 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licenses 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ LUNG disease or condition resulting in death) * Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year page 2 should be detached 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 2 D No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 6 Docher Specific Driv Other: 1 Tes 2 40 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After i tous-1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation Accident Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date of the cause of the date of the cause of the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of oprtifi 2 14 Name and address of person who completed cause of death (Item 23a) (Type, Print) NNAPOLIS MOLIYOI 11CHAD 31. Date filed (Month, Day, Year) State

Registrar

DEC 1 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 01 ZILM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rutherford Manor Assisted Living Davidsonville Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania Funeral 8. Date of Birth Days Min 1 M 2 Z (Month, Day, Year, 10/7/192 Director 578-20-2412 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖁 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 214 Holly Road 21037 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by ☐ Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural". 3 X Widowed 4 □ Divorced White Year or Dates injury or other traumatic event, the Me is al 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12th Secretary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Mentzer Blubaugh Edna Caroline Muelhlaus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Jennifer E. Jumalon/ Daughter 214 Holly Rd., Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Output

Description: cemetery, crematory or other place 5 Other (Specify) Lincoln Cemetery: 12/16/10 Brentwood. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home any 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy performed page 1 Yes 2 No Yes 2 No Physician: Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certificated filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Mille Hospital Other: 2 - No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Poth 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I only one) 29b. Signature and title of certifier 30 Name and address of person who co leted cause of death (Item 23a) (Type, Print) AU 13 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G912,2/14/2011, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 17, 2010 MICHAEL MATTHEW BRULEY, SR. 9:20A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 204 WARWICK ROAD CHESTERTOWN QUEEN ANNE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 185-48-3187 1 **X** M 2 \square F Days Hours Director 08/28/1957 PENNSYLVANIA 53 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD QUEEN ANNE'S CHESTERTOWN 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 204 WARWICK ROAD 21620 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE "natural", 3 Uidowed 4 Divorced Completed permit, Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 BUSINESS OWNER PAINTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM BRULEY THERESA ZGLESZEWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TONYA RIDER/DAUGHTER 106 KENNEDY DRIVE CHESTERTOWN, MARYLAND 21620 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 12/20/2010 CHESTER, MARYLAND 21. Signature of Funeral Service Lice FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MD 21620 23a. Pan 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ATHEROSCEROSIS Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 10a signed by the attending physician and deed detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part, I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Dyn drom 1 ☐ Yes 2 ☐ No 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မြ 1 🗌 Yes 2 No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5. Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 🗌 Yes 2 🔲 No after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 8026 -2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Da

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 25 AM Hnthony Dec 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Dorchester 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Months Days Hours Min Director Usual Residence of Decedent "natural", or items 23a or 28a-f sho 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Orchester 10e. Street and Number 10f. Zijo Code 10g. Citizen of What Country? Funeral 613 Mes Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces? 1985 by 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced Completed ack 200 permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is once. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wanda 20a. Method of Disposition 20b. Place of Disposition (Mame of Date 20c. Location - City or Town, State 1 V Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility uneralita MD. 2161 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ardievascu disease or condition resulting in death) minuly Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Diabe Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit (a) and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year should be detached signed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy performed? 2 1 No 1 Yes 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide
4 Homicide Investigation 24 hours a er deal Funeral Director 6 Could not be within 24 hours a er de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical E Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29c, License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 830 feak Dr. Chesa 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #21 Per FH G911 1/12/2011 JH State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 17:29P [™] <u>James Coleman, Jr</u> December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2727 Sun Valley Drive Charles Waldorf If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 🕅 M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min June 25, Yea Director Philippines ľ933 371-32-0665 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No <u>Maryland Charles</u> Waldorf 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? 23a Funeral 2727 Sun Valley Drive 20603 items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces'
1 X Yes 2 If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married ŏ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Philipino 3 Widowed 4 Divorced "natural", Completed Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th. <u>Administration Supervisor</u> U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Basilia Mungcal James Coleman, Sr. and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jordan Coleman/Son <u>Sun Valley Drive, Waldorf, MD.</u> 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Maryland Vets' Cem. Dec. 22, 20**1**0 Cheltenham, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home William Allen Smith M00544 3035 Old Washington Rd. Wall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 3035 Old Washington Rd. Waldorf, MD 20601 Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ DIABETES disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HRONIC KIDNEY DISEASE Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Exami for use as the burial-transit OBSTRUCTIVE SLEEP and that initiated events Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be HYPERTENSI P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo Division of Vital Records, VENTRICULAR HYPERTROPHY 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending 24 hours after death Funeral Director; A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one the 29b. Signature 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINE CENTER #100 WALDORF MOZOCOZ)IONNE 31. Date filed (Month, Day, Year) State 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Edward Cotton December 2010 2.12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown 7. Age (In yrs. last birthdav) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 X M 2 □ F Months Days Hours Min (Month, Day, Philadelphia, PA Director 169-34-0571 66 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Funkstown MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10145 Garis Shop Road 21734 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Flooring Buffer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Charlie Cotton 0de11 Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16839 Cavalry Drive, Williamsport,MD 21795 Donna M. Jones / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Dec. 23, 2010 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Q7C INOMO disease or condition Medical resulting in death) Due to (or as a contequence of): Examiner Sequentially list conditions Physician/Medical Examiner Due to (or es e consequence of): that y teaching to transcollar cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been sinned by the Attention of the control been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 as the k IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year ☐ Pregnant at time of death
☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 XNO Other: 1 Propatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Signat 29d. Date signed (Month, Day, Year) ahmod 2010 0063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00H-4 Chapic ahmood 0 DEC State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11 201 1-45 AM Medical 4a. Facility Name (if not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) June 27, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Director 479-24-6925 86 June 1924 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 🖵 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral J3416 Doncaster Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify. White "natural" 3 Widowed 4 Divorced Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Importanti: If item 27 is marked other than 'amy injury or other traumatic event, the Meonee. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Alvin Stransky Victoria Kiefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. DeCamp/Daughter 12526 Montclair Drive, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Signature of Funeral Service Licen MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ORONAR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Day Year signed by the at Id be detached fo Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No ☐ Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 ANatural injury 5 Pending s after death. 1 Yes 2 No Accident Investigation M Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and the of certifier è 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PERMANENTE SHIVAN 31. Date filed (Month, Day, Year) **DEC 15 2010** State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra/PMEND#30perMD, 12/17/10, BMW, Moco Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Winifred Yvonne Flanders Cameron <u>December</u> 2010 8:17 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours (Month, Day, Year) May 4,1928 Yrs. Director 257-50-8327 Georgia 82 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits 1 X Yes 2 No Silver Spring Maryland Montgomry 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 United States 917 Hyde Road 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🗷 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed Specify: Black 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Education Professor of Nursing other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o ပ parmit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic Alfred Flanders Katie Lee Chance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Cameron/Son 917 Hyde Road, Silver Spring, Maryland 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/17/2010 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington, D.C. 20012 23a. Part 1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Ischemic Cardiomyopathy Medical resulting in death) Due to (or as a consequence of) **Examiner** Coronary Artery Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 2 X No. 9 Unknown 9 Unknown ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Aortic Stenosis, Renal Failure 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 X No 2 🗆 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Tyes 2 🗷 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural injury work? 1 ☐ Yes 2 ☐ No. 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

68760 Box (P.O. Records, Vital of Hospital or Attending Division within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu To the Vithin 2 To the

Maryland 21215-0036

altimore,

State

Medical

29a. Certifier

(Check

31. Date filed (Month, Day, Year)

15

ana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LARCA MOT901 MARLE

Registrar's Signat

Registrar DHMH 17 Rev 7/2009 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

AUE

certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D27837

TAKOMA PARK MARVIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend#16b per FD State of Maryland / Department of Health and Mental Hygiene AA Co Health Dept_12-15-10 KAH Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death CHASE Physician/ MARY 2010 1617 12 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arunde1 Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗷 F Months Min. (Month, Day, Year) 213-14-3523 Director 92 Aug 918 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 ☐ Yes 2 🏋 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 620 Second St. 21403 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: 3 ¥ Widowed 4 ☐ Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Covernment <u>Time Keeper</u> 12th 4vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph J. Turner Lula Meredith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Braxton McNeill(Grandson) 601 21201 N. Packer St. Baltimore, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran : 12-17-10 Crownsville, Md. 21. Signature of Funeral Service Licensee MMame and the confession of the contract of th 821 West St. Annapolis, Md. Beese 110048-3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Betweer Opeet and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 No 1 Yes **Division of Vital** funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier pleted gause of death (Item 23a) (Type, Print) and address of person 31. Date filed (Month, Day, Year) State DEC 15 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Louise Veronica Carroll 2010 12:52 P. ^M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George's Hospital Center Cheverly Social Security Number 7. Age (In yrs. last birthday) 90 vrs If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours 1 M 2 XF Days Min. Director 578-20-1135 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. P.G. Hyattsville 1[™] Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2013 Barlowe Place 20785 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces permit. Page 1 and 2 should be filed within 72 hours after d Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or is any injury or other traumatic event, the Medical Examina ane. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Postal Clerk U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifton Chatman, Sr. Emma Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Michael D. Chatman/Grandson 10201 Juniper Drive, Mitchellville, Md. 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 12/15/10 Landover, Maryland ^{22. Name and Address of Facility} See Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. Signature of Funeral Service License aui 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CARDIAC Physician/ FATAL ARRHYTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ORON ARY ARTERY esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): I or Attending Physician: The law requires that the death certificate be executed after death. HYPERTENSION and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical DIABETES Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ၉ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practices to the cause(s) and manner as stated. (Check 29b. Signature 29c. License number D63688 30 Name and address of person who completed cause of death (Item 23a) (Type Print) e Cheverly no 20783 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Jacqueline Lee Comfort Dec 2010 Medical :20am a Facility Name (if not institution give street and number)
Montgomery Village Care and 4b. Citv. Town, or Location of Death Examiner 4c. County of Death Rehabilitation Center Gaithersburg Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 9, Birthplace (State or Foreign Country) Funeral 1 □ M 2 🗓 F Hours Min. Director 217-40-1580 68 194 Usual Residence of Decedent 10a, State 10b. County with the Maryland äţ 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sl notified 1X Yes 2 ☐ No MD Montgomery Gaithersburg 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 107-B N. Summit Ave. 20877 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, "natural", or ite Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify. Specify: White 3 - Widowed 4 X Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Child care/ Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marshall Dayton Virginia Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Jean Tobery/ Daughter 107-B N. Summit Ave. #8, Gaithersburg, MD 20877 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Life Legacy 1 ☐ Burial 2 ☐ Cremation 3 ☐ H
4 🕅 Donation 5 ☐ Other (Specify) Burial 2 Cremation 3 Removal from State 12/10/2010 Tucson, AZ Foundation 21. Signature of Funeral Service Cen 22. Name and Address of Facility Thibadeau Mortuary Service, p.a. M00956 7 Park Ave., Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last sequining of an and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Month Day Year Pregnant at time of death signed by the arid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No 2 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work's 1 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 only one) Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 005757v 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W30 ave State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CARTER RUDISILL December 13 ROLYN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MERITUS MEDICAL WASHINGTON HAGERSTOWN Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Feb. 24 7. Age (In vrs. last birthday **Funeral** Days Min. 1 🗆 M 2 🗓 F Mary Land 1939 **Director** 214-36-0053 71 Usual Residence of Decedent 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f sho Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? Funeral 1009 Salem Avenue 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Assistant Vice President</u> Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene B. Rudisill Jane E. Geist 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Carter - Husband 1009 Salem Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 12/17/10 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Halut 415 E. Wilson Blvd. Hagerstown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MYOLARDIAL Immediate Cause (Final Onset and Death Physician/ INFARLTION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami that the death certificate be executed Due to (or as a consequence of): nding physician use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Year Pregnant at time of death Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy 1 Tes 2 No ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? 2 XNo Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Dav. Year) 2010 00066092 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALMAN SH-10 PICWY Colombit MD MEH3003 8850 COLUMBIA 100 Year) 31. Date filed (Mo 32. Registrar's Signatur State Registrar

Box 68760

P.O.

Records,

Division of Vital

State Registrar

DHMH 17 Rev 1/2001

Registrar DLG & 1 Z(

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAURE DE GRACE.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month NOV. **Physician** THOMAS LEMORINE DATES 25 Year 2010 11:33 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine 10800 LAKE ARBOR WAY MITCHELLVILLE PRINCE GEORGE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 29 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. 12 M 2 □ F VIRGINIA 1936 Director 224-44-4453 Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MARYLAND PRINCE GEORGE Director MITCHELLVILLE 1 √ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10800 LAKE ARBOR WAY 20721 U. S. A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygienn Important: If item 27 is marked other that any injury or other traumatic event, the 2008. METRO OPERATOR TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEMORINE DATES TRACY WHITE ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS BLACKWELL DATES (WIFE) 10800 LAKE ARBOR WAY MITCHELLVILLE, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) SHILOH BAPTIST CHURCH CEM. 12/1/2010 REEDVILLE, VIRGINIA 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility 6784 MARY BALL RD BERRY WADDY FUNERAL HOME LANCASTER, VA 22503 23a Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each ne. Approximate Interval Between Onset and Death Immediate Cause (Figal Physician disease or condition resulting in death) /Medical Due to r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş cate has been sit 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform Division of Vital 2.2 No 1 □ Yes 2 1 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗀 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Varifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only

State

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29b. Signature and title of certifier

LEON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Registrar

MERCANTILE

29c. License number

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dobson Frances Pauline December 11,2010 9:40A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill Nursing & Rehab Montgomery Bethesda Birthplace (State or Foreign Country)
 Town Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 🗆 M 2 🗶 F Months Days Mau 02, Year) 20 034-18-5037 **Director** Iowa 90 Usual Residence of Decedent 28a-f shov 10a, State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2730 Wisconsin Avenue, NW, #24 20007 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 🗓 Yes 2 🗆 No 1943—
If Yes, Give 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Warington Dobson Ella Harriet Kellerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean Dobson - Nephew 3520 Greenway Chase Dr., Florissant, MO 63061 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 X Removal from State White Chapel Mem Grdn! 12/17/2010 | Gladstone, Missouri 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. <u>11800 New Hampshire Ave., Silver Spring, MD20904</u> 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Complications of Head & Neck Cancer disease or condition resulting in death) 4 weeks Medical Due to (or as a consequence of): Examiner Head & Neck Cancer 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): inding physician a use as the burial-Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. Hospital or Attending Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 \square Yes 2 \boxtimes No 3 \square Probably 4 \square Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 2 X N 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending death. thin 24 hours after death.

the Funeral Director: At mpleted filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 To the P within 24 To the F complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

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Thomas Masterson,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.,

D50534

1313 Dolly Madison Blvd., Suite 302, McLean, VA 22101

December 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER Jean Donnelly L. 2010 9:00P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 915 Topmast Way Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Washington, DC Director 578-40-5267 2/20/1929 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than 27. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Tes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 915 Topmast Way 21401 USA 13. Was Decedent of Hispariic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Catholic Schools School Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James J. Lyons Emma Loef1er 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2005 Gresham Lane, Davidsonville, MD 21035 David M. Donnelly/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Resurrection Cemetery 12/15/2010 Clinton, Maryland 21. Signati of Funeral Service Licen 22. Name and Address of Facility George P. Kalas Funeral Home Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or col shock, or heart failure. List only se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 9 Unknown signed by the a Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 → No 3 → Probably 4 → Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? Yes 2 -2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Funeral Director: After this certificate has been s completed filled in by the funeral director, page 2 should after death 24 hours within 2 To the I

State Registrar

Medical

4 Homicide

29a. Certifier

(Check

only one)

31. Date filed (Month

3

29b. Signature and title of certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Redistrar's Signature

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ Month 8:07 PM DIXON 200 DECEMBER THOMAS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A TIMORE HARBOR HOSPITAL 8. Date of Birth (Month, Day) NOV 19 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. Year) 926 1 💢 M 2 🗆 F Maryland Director 84 220-18-8693 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Tes 2 X No Glen Burnie Marvland Anne Arundel 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Completed by Funeral 21061 USA 1050 Cedar Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 Never Married 2 Married X Yes Yes, Give 2 No 1 ☐ Yes 2X No Specify Specify: White 3 ₩ Widowed 4 Divorced Year or Dates 1944-46 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed Electrician 12th æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mabel Bozel Thomas H. Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21666 19a. Informant's Name/Relationship (Type, Print) 240 Eareckson Lane Stevensville, Md. Christine A. Puglisi(Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 12-7-10 Baltimore, Md. Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Mame 1988 Sof Aulit Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 m00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final CARDIOVASCULAR DISEASE Physician/ ATHEROSCLEROTIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 30 YEARS HYPER Sequentially list conditions. sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Doe to for as a consequence on Hospital or Attending Physician; The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 Pregnant signed by the aid be detached f 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown OBSTRUCTIVE PULMONARY DISEASE 1 Tes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ြု 24 hours after death.

Funeral Director: After this . Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MEDICAL DOCTOR DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNETH MWATHA 3001 SOUTH HANDUER STREET, BALTIMORE MARYLAND 21225 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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	State of Maryland / Department of Health and Mental Hygiene [] 6 8								# 158U
	Registrar Certificate of Death Reg. No.						. No.		
Physiciar Medica			1. Decedent's Name Kirst, Middle, Las	Dearrin	7(2. Date of Death	Day Oar	3. Time of Death
	Exami	ner	A Socility Name (if not institution) give	DRG ES HOSPIT	4b. City, Town, o	Location of Death		4c. County of Dear	th
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State					thplace (State or Foreign untry)	
-	ihow at	Director	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		11-15-1	44111	10d. Inside City Limits
	ne Maryla r 28a-f s notified		MD P6	Mit	chellvi 10f. Zip Code	lle			1 Stes 2 □ No
	th with the ns 23a comust be	Funeral	10505 Clea	iry Lane	20	721	10g.	. Citizen of What Co	ountry?
336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	d by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
3 Widowed 4 Divorced Year or Dates. Army 16a. Decedent's Usual Occupation								IGCK	
Maryland 21215-0036	within 72 ł rgiene. ner than "n t, the Medi	Completed by	(Specify only highest grade Elementary/Seconday (0-12)	de completed) ((Give kind of work done of ife. DO NOT use retired)	during most of workin	g 166	o. Kind of Business	
d 2	filed wi al Hygie d other vent, t	Be (17. Father's Name (First, Middle, Last)	1 4	THOSOK	ator			ment
an	be file ental ked c	2	Eddia De	Province		18. Mother's Name	(First, Middle, Maid	len Surname)	
37	should and Me		19a. Informant's Name/Relationship (Type	De. Print).	Mailing Addungs (Chart	14011		CITTIA	
Š	and 2 sh Health a tem 27 is		Joel Dearkin		Mailing Address (Street a		Bowle Number, City	or Iown, State, Zip	Code)
re,	1 and of Hei item		20a. Method of Disposition	20b. Place of I	Disposition (Name of	D		Location - City or	Town, State
<u>=</u>	Page Tent c		1 Burial 2 Cremation 3 4 Donation 5 Cother (Specify,	Removal from State	crematory or other place	(e)		Dock	Jan bury
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Cervic Lipense	e)/(/201-10:	22. Name and Addres	ss of Facility	Seman	FUNERO	1 Herris
ш		L	- MUUUUU	M Cremen	75270			ercky Rel C	11/100 CO135
	¥		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on Immediate Cause (Final	cations that caused the death. Do no cause on each line.	t enter the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
P	nysician/ Medical		disease or condition resulting in death)	Due to (or as a consequence of)	neuri bl	OCK			Onset and Death
	Examiner	,		C TO KE				24	
	_ =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						
Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
	be exe	calE	resulting in death) Last	Due to (or as a consequence of)	:				
260	phys			J					
89	nding use as	N/M	IF FEMALE: 23b. Was decedent pregnant 2.	3c. If yes, outcome of pregnancy				22d Data of dall	
in the past 12 months? Columbia Columbi						23d. Date of delivery Month Day Year			
or the state of th						the cause of death?			
ds, I	been signed by the should be detached	ed by					1 🗆 Yes	2 No 3 Pr	obably 4 Unknown
Sor	as bec 2 sho	plet					24a. Was an		opsy findings available
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the cause									
<u> </u>	this craldin	<u>۵</u>	1 ☐ Yes 2 💢 No H	1 Inpatient 2 ER/Outp					
o uo	ath. or: After he fune	Certificate:	27. Manner of Death 28a. Date of injury 1 Natural 5 Pending 28b. Time of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No						
IVISI	after de Directo		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			8f. Location (Street and Number or Rural Route Number, City or Town, State)		
Loepite	4 hours Funeral	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	ian: To the best of my knowledge, dear. On the basis of examination and/or in	ath occured at the time,	date and place, and	due to the cause(s)	and manner as stat	ed.
4	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							tated.	
٤	. ≽ ⊨ છ	29b. Signature and title of certifien 29c. License number 29d. Date signed (Month, Day, Year)							
	5	-	30. Name and address of person who cor	npieted cause of death (Item 23a) (Typ	De. Print)	010	10	x -16-	2010
(14		M. SAFARAZI	MD. 3001 HO.	SpitalDy	Cheve	Rly 1	no 20	2010
	Stat Registra		B1. Date filed (Month, Day, Year) NEC 2 0 2010	32. Registrar's Signature	1				

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			For State		State of	Maryla	and / Dep		nt of F te of E		and I	Mental H				4 58
			Registrar 1. Decedent's Name (First	st, Middle, L	ast)			unca	ie oi L	Jean		2. Date of I	Reg. N	No.		3. Time of Death
	Physician/ Medical Thelma L. Davis											Month	c. 1	2 ^y , 20	ľ o r	1:15 A M
	Exami	4a. Facility Name (if not institution, give street and number Calvert Manor Nursing				,		1	y, Town, or ising		-		4	tc. County Cec	of Death i1	
	Funeral Director		5. Social Security Number 221–18–5420	6	Sex 1 M 2 F	Age (in yr.	s. last birthday) Yrs.	If Und Months	er 1 Year Days	If Under Hours		8. Date of B (Month) Nov 2		929	g. Birthp Count Kem	lace (State or Foreign Plesville, P
	and show dat	io	Usual Residence of Dece 10a. State 10b.	. County		10c.	City, Town or Location				-			10d. Inside City		
	Mary 28a-f ootifie	irec	MD	Ceci1		R	ising	Sun		_						1 Yes 2x No
	vith the 23a or st be	ral	10e. Street and Number 1881 Teles	oranh	Road				ip Code 21911				10g. 0	Citizen of W		try?
	leath v items ier mu	Funeral Director	11. Marital Status	Бгарп	12. Was Decede	ent Ever in	J.S. 13.				igin? (Sp	ecify Yes or N	D-		- America	an Indian.
36	after on samin	d by	1 ☐ Never Married 2 3 ☐ Widowed 4 🛣	1 Never Married 2 Married Armed Forces? 1 Yes 2 If Yes, Give				Ever in U.S. 13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 Yes 2 No Specify:						k, White, e	tc.	
21215-0036	hours natura lical E	lete	15.	es	16a. Deced						16h	Specify: Kind of Bus	whi			
121	hin 72 ne. than " ie Mec	Be Completed by	Elementary/Seconday		rade completed) College (1-4	or 5+)	(Give life. D	kind of w O NOT us	ork done d e retired)	uring mos		ing			•	
d 2	led wit Hygie other ent, th		12 17. Father's Name (First, M	Middle, Last)			Asse	шоту	Line			e (First, Middl				ical Suppli
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Baltimore, Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Re Jason D. Ho	elationship (o llett	Type, Print) : (grands	on)	19b. Mailir 739	ng Addres Sa1	s (Street a em Ch	nd Numbe urch	er or Rura	Newa:	per, City c	or Town, Sta	ate, Zip Ci 702	ode)
Jore	ige 1a nt of H t: If ite		20a. Method of Disposition 1 Burial 2 Cre	emation 3	Removal from S		Place of Dispo cemetery, cren	sition (Na natory or	me of other place	e)		Date	20c. I	Location - 0	Dity or Tov	vn, State
altin	permit. Page 1 a Department of F Important: If ite any injury or ot	3	4 Donation 5 21. Signature of Funeral S				emblesv ethodiæ					16,201) Ke	emble:	svill	e, PA
ä	permi Depar Impor any ir		>									omes,	Inc.	3924	Cond	ord Pike
	Medical Examiner the burial-transit	al Examiner	23a. Part 1. Enter the diss shock, or heart failur Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	re. List only o	Chronic Obstructive Pulm Dise							e (Aproximate Interval Between inset and Death			
). Box 68760	ath certifi attending for use as		IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ ❤ to 9 ☐ Unknown			th 2□Fe nt at time of	h 2 ☐ Fetal death 3 ☐ Ectopic pregnancy t at time of death 5 ☐ Other (specify)							23d. Date of o		
О.	requires that the de been signed by the should be detached	þ	Part II. Other significant of	conditions of		h but not re	sulting in the ur	nderlying	cause give	n in Part I	ı.					cause of death?
rds	require been si should	Completed			Type I							1 1	Yes 2	□ No 3	Proba	ibly 4 🗌 Unknown
ecc	e has l	dmo		nentic								24a. Was auto	psy	prior to completion of cause of		
a F	ian: Ti artificat ctor, pa		25. Was case referred to mexaminer?						26. Plac	e of Deat	th (Check	perf 1 \sum Yes	2 P N	lo 1	Yes 2	No
Ţ.	Physician: The lav r this certificate has eral director, page 2	욘	1 Yes 2 No				ER/Outpatient			4 Nu	ırsing Hor	me 5 🗆 Res	idence (6 🗆 Other	(Specify)	
o uc	tth. : After e funer	cate	1 Natural 5	Pending Investigation		njury Day, Year)	28b. Time of injury	м 2	8c. Injury a work?	at es 2□	- 1	28d. Describe	how injur	ry occurred		
Division of Vital Records, P.O.	al or Attending P s after death. Il Director: After t d in by the funera	Certificate:	3 Suicide 6 S	Could not be determined	e 28e. Place of	Injury - At h etc. <i>(Speci</i> i	ome, farm, streety)					28f. Location (City or To			or Rural R	oute Number,
-	Io the Hospital or At within 24 hours after of To the Funeral Direct completed filled in by	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and due to the cause(a and dies he	a Alexander	e(s) and manner stated.		
	with Volt	[29b. Signature and title of o					290	. License r	number			29d. Da	te signed (/	Month, Da	
		-	30. Name and address of p	person who	completed cause a	f death //+	n 22a) (Time D	int)	000	583	54		12	16/10	>	
	3		DEIL E. LA	ITTIN,	M.D. 10	11 COI	OPIAL	Dag	Ric	فا مو	Sun.	MO	219	î (i		
	Stat Registra	Ç	1. Date filed (Month, Day, 1		32. Regis	strar's Signa	ature	1	1	3						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 10:55 p^M Cheryl Layne Draper Physician/ 2010 December Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Northwest Hospital 8. Date of Birth (Month, Day, Year) Nov. 5 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 5. Social Security Number Maryland Min Funeral Months Days Hours 1 □ M 2 🛛 F ĩ′949 61 216-52-7245 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State Director 1 Yes 2 No Elkton Cecil Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21921 U.S.A. 528 Blair Shore Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after death 11 Marital Status Black, White, etc. Yes 2 X No 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 If Yes. Give 3 Widowed 4 Divorced Year or Dates. 16b. Kind of Business Industry V.A. Maryland Healthcare Perry Point, 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) Inventory Management Specialist Twelve 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) Jean N.Jenkins John William Deibert မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 520 10th Street, Fieldale, Virginia Shaun W. Draper (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
R.A.Ferris & Co., Inc. 20a. Method of Disposition West Chester, 1 Burial 2 X Cremation 3 Removal from State 12/19/10 <u>Pennsylvania</u> 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Perryville, Son Funeral Home, P 21. Signature of Funeral Service Ligens 10M/BAI Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Main metatases ancer with hung Mont Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Hospital or Attending Physician: The law requires that the death certificate be to a hours after death.
 Funeral Director: After this certificate has been signed by the attending physicial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical 4 Nursing Home 5 Residence 6 Nother (Specify) Division of Vital Be funeral director, Other: Hospital 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ဂ္ 28d. Describe how injury occurred 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the 29d. Date signed (Month, Day, Year) Signature and title of certif SUITE 203 BALTIHOLF, UD ZIZO9 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print)

KANLO W. MFMLTT 2835 MITH AVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Voai Physician/ 39 М 2010 Medical Town, or Location of Death la. Facility Name (if not institution, give street 4c. County of Death Examiner BALTIMORE CITY 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1**∑** M 2 □ F 4 (Month, 9a) 6a2 K Pountry) 406-04-9444 48 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director LA PLATA 1 🗆 Yes 2 🔀 No CHARLES MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a on the Medical Examiner must be Funeral U.S.A. 20646 8070 ANNAPOLIS WOODS ROAD within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE If Yes. Give Completed 3
Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOME REPAIRMAN AAA POWERWASHING 12th traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) should be file and Mental H 0 NADINE HOLLAND CALVIN DUNCAN t. Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) LORI A. DINCAN-SPOUSE 8070 ANNAPOLIS WOODS RD. LA PLATA, MD. item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of I Important: If its any injury or of 1 Burial 2 X Cremation 3 Removal from State METROPOLITAN CREMATORY 12-30-10 4 Donation 5 Other (Specify) M00479 22 Name and Address of Facility
KAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one complications on each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ⊋hysician/ disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): physician Physician/Medical that the death certificate be P.O. Box 68760 the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for it in the past 12 months?
1 Yes 2 A Month Year Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Division of Vital Records, Hospital or Attending Physician: The law requires Completed 24a. Was an . Were autopsy findings available prior to completion of cause of page 2 s has perform death? Yes 2 🔽 certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 1 Impatient After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 🕒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 🗆 only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 23-2010 eted cause of death (Item 23a) (Type, Print State Registrar

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			For State	State of M	laryland	•		Health and	Mental Hy	gien	e 2010	1.1691
			Registrar	o#)		Cer	tificate of	Death		Reg. N	lo. — — — —	7 71004
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	or 28	څ	10e. Street and Number				10f. Zip Code			10g. (Citizen of What Co	ountry?
	with with s 23a	eral	701 Glenwood S	t. Apt 6	05		21	401			USA	
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Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	ted by	1 Never Married 2X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.	No		Yes 2 X	1	lack			
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lan	ild be file Mental larked c	유	James Edward E	well					Ann Jo		-	
ary	hould and M s ma		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (Stree	t and Number or R	ural Route Numbe	r, City	or Town, State, Zij	o Code) 21401
	and 2 s Health a tem 27 i		Delmus Thompso	n(Husban	d)			od St. A				
ore	of He of He if item		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐	Removal from State			sition (Name of natory or other pla	ace)	Date	20c.	Location - City or	Town, State
Ĕ	Page ment tant:		4 Donation 5 Other (Speci	fy)	Me ⁻	tro C	remato:		-10-10		ltimore	
Baltimore,	permit. Page 1 and 5 Department of Healt Important: If item 2 any injury or other		21. Signature of Funeral Service Licen					Secon Secility SO1				
	ED = 00	Н	23a. Part 1. Enter the disease, or com-	ease m		9 -				_	Ma. 21	
	400000000000000000000000000000000000000		shock, or heart failure. List only o	one cause on each line	e.	. Do not ente			c or respiratory an	031,		Approximate Interval Between Quiset and Death
	Physician/ Medical		disease or condition resulting in death)	a. Due to (or as	a conseque	ence of):	CAN	-tK				Priset and Death S
Second	Examiner			240 10 (01 45	a concoque	51100 017.						
		iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	ence of):						
	uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	C								
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9289	artifica ling p e as t	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	101						
Box (ath ce attenc for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 4 Pregnant a	2 Fetal	death 3 [Ectopic pregnal	псу			23d. Date of del Month	ivery Day Year
Ď.	the a	ysi	1 Yes 2 No 9 Onknown	9 Unknown	at time or de	Juli 0	Garer (aposity)					
P.O.	requires that the death certificate I been signed by the attending phys should be detached for use as the	Completed by Physician/Medi	Part II. Other significant conditions of	ontributing to death b	out not resu	lting in the u	nderlying cause o	jiven in Part I.	23e. Did to	bacco	use contribute to	the cause of death?
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Records,	w req	plet							24a. Was autor		24b. Were au	topsy findings available completion of cause of
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of Vital	hysic this co	To Be	1 ☐ Yes 2: No			R/Outpatien	1 3 LL DOA		Home 5 Hesic			ify)
0	h. After funer	Certificate:	27. Manner Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Dag	y, Year)	28b. Time of injury	28c. Inju wo M 1	ıryant rk? ∐Yes 2. ∐No	28d. Describe h	ow inju	iry occurred	
Siol	deatl ctor: y the	ţį į	2 Accident Investigation 3 Suicide 6 Could not b		urv - At hon	ne. farm. stre			28f Location (S	treet a	nd Number or Rui	ral Route Number.
Division	tal or A	ē	4 Homicide determined	building, etc	c. (Specify)				City or Tow	n, Stat	e)	EV.
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination	and/or investi	gation, in my opin	ion, death occurred	at the time, date a	nd plac	e, and due to the	cause(s) and manner stated
	To the within To the company		29b. Signature and title of certifier	JO F TOO MOTION TO THE	A	A. Istribuge, u	29c. Licen				ate signed (Month	
	20		G. Lightp.	ct-Tax	10/1	Sla	RII	8103		(2	-131:	2010
	1		30. Name and address of person who	completed cause of	eath (Item 2	23a) (Type, F		\			\ A A .	
			GENEUTEVE !	IGHTE	1-10	AYLO	R, 445	DEFEN:	SE HWY	A,	NUTTOL	15, M.D. 2140
	Sta	е	31. Date filed (MorDEC YO'9 20	10 32. jegistra	ar's Signatu	B. 100	well			1		•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lloyd $_{\rm L}$. Elder, Sr. December 09, 2010 11:55 p^M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10717 St. Margaret's Way Silver Spring Montgomery Social Security Number 6. Sex 8. Date of Birth (Month, Day, Jan• 11 9. Birthplace (State or Foreign Country)
MD **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days 1 🔀 M 2 🗆 F Months Min. Hours **Director** 214-28-9352 Yrs 87 Jan. 1923 Usual Residence of Decedent effinit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importanti If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any pine. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 1 ☐ Yes 2 🛂 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10717 St. Margaret's Way 20902 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. ģ 1 Never Married 2 km Married Baltimore, Maryland 21215-0036 ☐ Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Meat Cutter Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည James L. Elder, Sr. Mabel L. Briggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey C. Elder/Wife 10717 St. Margaret's Way, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1x Burial 2 Cremation 3 Removal from State Dec. 15 St. Mary's Cemetery Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee Francing Address Collyins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Chronic Congestive Cardiomyopathy Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Arteriosclerotic Cardiovascular Heart Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year cate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 X No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 🖺 No Other: 2 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Investigation 1 ☐ Yes 2 ☐ No Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 10 D55522 Dec. 10, 2010 aller 1 ac

State Registrar 31. Date filed (Month, Day, Year)

Robert H. Gerard, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VOID

CERTIFICATE

2010-41686

SEE

CERTIFICATE

2011-03414

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ ICHAE LANOW SKI 03 1 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) 89 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Sept 26, 9. Birthplace (State or Foreign Funeral 1 **Z** M 2 □ F Months Min. 044-14-8282 Hours Director Pennsylvania 1921 Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Hyattsville MD 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5122 Crittenden Street 20781 USA or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ John Filanowski Apoloniae Tubiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Rogers / Daughter 7606 Browns Bridge Road Highland, MD 20777 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 13 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. 2010 Park Funeral Home 495 Ritchie Highway Severna Park, MD 21146 Signature of Funeral Service Licensee 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause of each line. Approximate Interval Between eset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical nding p IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ō Pregnant at time of death Month Day 1 Yes 2 No ned by the a e detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be d ģ Records, 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed' 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital 2. No Other: 1 Yes ဂ 1-Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completed 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 7 WI iori Name and address of person who completed cause of death (Item 23a) (Type, Print EFE NSE 752010 31. Date filed 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 2010 Rachel A. Forney 7:28 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Month, Day, Y Hours 75 **Director** 283-28-4461 Ohio June Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Me iteal Examiner must be notified at 10a. State 10c. City. Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🖁 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 926 Shipmaster Ct. 21401 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the May injury or other traumatic event the May injury or other traumat College (1-4 or 5+) 12th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Russell Esterly Eleanor Sample 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fredric D. Forney/ Husband 926 Shipmaster Ct., Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Durial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Signature Kalas Crematory 12/8/10 Edgewater, Maryland çe Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Ischemic cardiomyopathy 8 years Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit led by the attending physician and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes 2 ☐ Unknown 9 I Inknown n signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown High blood pressure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical examiner? 8 B 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🛣 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Robert St. Green D28 37 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solevini Is (RS; Dunyoles OLD 21401 A Ste Guzen 31. Date filed (Month, Day, Year) **DEC 0 8 2010** Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND# 1 PER PHY Registrar 12/8/2010 AACO HEALTH DEPT CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death S. Anne Fach 3. Time of Death Physician/ S . FACH 11:50 AM NOV Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death ARUNDEL ANNE ARUNDAL MEDICAL CENTER ANNAPOLIS, MD ANNIE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 1 **Funeral** 9. Birthplace (State or Foreign 301-24-9474 1 🗆 M 2 🛛 F Months 80 Director Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c City Town or Location Director 10d. Inside City Limits MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 324 Hollyberry Road 21146 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 X No þ 1 Never Married 2 X Married hours after Baltimore, Maryland 21215-0036 should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Callege (1-4 or 5+) Registered Nurse HealthCare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Nelson Fellows Emma Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau G. Nicholas Fach / Husband 324 Hollyberry Road Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory, INC. 2010 Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Ho 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 4. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final a NON-ST ELEVATION MYOCARDIAL INFARCTION Onset and Death (Inysician) disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CELL LUNG CANCER 5MALL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) executed the burial-transi THROMBU CYTDPENIA

Due to (or as a consequence of): and that initiated events resulting in death) Last attending physiciar Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be ANEMIA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day the 9 Unknown 9 \ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Biscase 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an After this certificate has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: 은 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Signature and title of certifier llannen 065292 NOV. 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIA GAREL ANNE ARUNDER MEDICAL VILLANLIEVA, MO State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Day John Thomas Fitzgerald 2010 10:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Prince George's 4b. City. Town, or Location of Death Regional Hospital aurel Laure 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 3. Date of Disc... (Month, Day, Year) 13-30-1.927 1 **X**M 2 □ F Months Days Hours Min Director 230-32-5178 83 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Prince George's Laurel 1 X Yes 2 ☐ No MD 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9601 Muirkirk Rd. 20708 AZU 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 XWidowed 4 ☐ Divorced Specify: Black Completed f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Equipment Operator Construction Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Sallie Ann Dixon Toy Fitzgerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Heatth a Important: If item 27 is any injury or other tra Timotheus Fitzgerald / son 12814 Meadow Brook Ln., Waldork, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 12=16-2010 ■ Burial 2 Cremation 3 Removal from State emetery, crematory or other place)
FT_LINCOLN CEMETERY brentwood.md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pneumonia Ph sician/ disease or condition **▼** Medical resulting in death) Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any leading to immunity cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Decubitus Wound To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 ☐ Pregnant at time of death g ☐ Unknown Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure to Thrive Completed 1 Yes 2 No 3 Probably 4 Unknown Acute Respiratory Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag performed? Yes 2 N 2 🗌 No 1 Tyes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death 1 Natural 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 5 Pending injury Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Deficient Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Grant Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on of certifier Signa 29c, License number 29d. Date signed (Month, Day, Year) D0066284 December 9, 2010 nd address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road MD Laurel Regional Hospital Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ obent MINIS Month 420N Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's Social Security Number 1 Year | If Under 24 Hrs. Days | Hours | Min. **Funeral** 6. Sex Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) April 6, I 9. Birthplace (State or Foreign 1 X M 2 | F Months **Director** Country)
Washington 213-44-7313 64 1946 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Feamings must have the 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☑ Yes 2 ☐ No 10e. Street and Number ems 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 699 Bestgate Road 21401 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes : 2 🔀 No 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Auto Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert George Fuerst, Sr. Rosemary Wheatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sean C. Fuerst / Son 132 Foxtrap Drive, Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metropolitan Crematory 12/7/2010 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ ACIDUS15 Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner RO Pentusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine nterial THAUM BOSIS sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical law requires that the death certificate be ATHEROSELEROSIS Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Pregnant at time of death Month Yes 2 No Day Year the detached 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 23e. Did tobacco use contribute to the cause of death? should be THNONBINDY Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? Yes 2 No 2 🗌 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ပ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director; After 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npleted filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20770 73 MIAN BAYLY HANOVER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Albert Lee Frazier, Jr. <u>cember</u> 8,2010 :44 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Doctors Community Hospital Prince George's Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 Months Hours Director 579-36-1498 1929 August Washington. Usual Residence of Decedent or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location aţ Director 10d. Inside City Limits Examiner must be notified Maryland Prince George's Riverdale 1 🛛 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6407 62nd Place 20737 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. ģ 1 Never Married 2 Married X Yes 2 No 72 hours after If Yes, Give 1 Yes 2 No Specify: "natural", 3 Midowed 4 Divorced Year or Dates. 1951-1953 Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than be filed within Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications Cable Technician 12 traumatic event. Be 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Malden Surname) ဂ Albert Lee Frazier, Sr. Catherine E. Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy L. Daymont / Daughter 9304 4th Street, Seabrook, MD 20706 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 12/13/2010 Brentwood, Maryland . Signature of Fundal Service License 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) COMMUNIT Medical Due to (or as a consequence of): Examiner 03372 كالمصداد Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPURUPINEDIO 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 100 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 🗌 Yes 1 Enpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

2 15 MA

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature ap-

THOINKS

31. Date filed (Month, Day, Year,

3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MASU

MI

32. Registra

7525 GRAZIWA-

29c. License number

D22220

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edith Lucille Fleshman 8:25 PM December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death #800 9014 Rhode Island Avenue, College Park Prince George's 8. Date of Birth
(Month, Day, Ye
Tuly 19, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Hours 1930 Beltsville, Maryland 218-24-2469 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Maryland Prince George's College Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 20740 9014 Rhode Island Avenue, #800 USA death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married ☐ Yes 2 🖾 No Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White "natural" Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be uge 1 and 2 should be filed nt of Health and Mental Hy t: If item 27 is marked otl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel I. Cochran Nettie Lizear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Mae Melton / Daughter 5105 Kenesaw Street, College Park, MD 20740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Hall Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 12/13/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) . Signature of Janeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ Post Inflammatory Pulmonary Fibrosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Dust to for as a consequence of cause. Enter Underlying physician and s the burial-transit Exami that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Pregnant at time of death the 9 Unknown 9 Unknown P.O. detach þ signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown nis certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year) State OEC 1 3 2010 Registrar

rang Ollle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

only one)

29b. Signature and title of certifier

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D23743

29d. Date signed (Month, Day, Year)

12/10/2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Martin D. Weltz, 7525 Greenway Center Drive, Suite #205, Greenbelt, MD 20770

29c. License number

Kelly Terrel Fisher
10-09305

Places

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Unk Unk	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death													
Physicia	an/	Registrar 1. Decedent's Name (First, Midd	le,Last)						2. Date of De	Reg. No.	3. Time of Death			
Medical Exami		Kelly Terrel	1 Fisher						Month December	Day Year er 4, 2010				
		4a. Facility Name (if not institution				4b. Ci	ty, Town, or L	Location of D		4c. County of	Death			
		Baltimore Washington Medical Center Glen Burnie								Anne Arundel				
Funeral		5. Social Security Number		7. Age (In yrs.	last birthday		Jnder 1 Year onths Days	If Under 2	4Hrs. 8. Date of B Min.	irth(MM/DD/YYYY)	Birthplace (State or Foreign			
Director		213-96-9965	1 M 2 F		30	Yrs.	Jilais Bays	Hours	Nov 1	1980	Maryland			
any		Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Lo	ocation					10d. Inside City Limits			
			Arunde1		len B		6				1 Yes 2 No			
nylan 8a-f sh	cto	10e. Street and Number			i di		Zip Code			10g. Citizen of Wha				
ith the Maryland 23a or 28a-f show notified at once.	Director	448 Gatewood	C+				21061	1		USA	•			
with t		11. Marital Status	12. Was Dece	edent Ever in U			edent of Hisp	oanic Origin?	(Specify Yes or N		American Indian, Black,			
death r iten	Funeral	1 X Never Married 2 M	arried Armed Fo	rces?		If Yes, sp	ecify Cuban,	Mexican, Pu	erto Rican, etc.)	White,	etc.			
after	by F		orced If Yes, Give Year or Dates:	-	1	Yes	2 X No	specify:		Specify:	B1ack			
hours natur Exam	ed	15. Decedent's Education (Spe					ual Occupation working life.		of work done retired)	16b. Kind of Busi	iness/Industry			
36 in 72 han "	plet	Elementary/Secondary (0-12) 12th	College (1-	-4 or 5+)			.ft Or			Aeris C	Company, LLC			
-00; d with giene fher t	Completed	17. Father's Name (First, Middle,							ame (First, Middle,		Jompan, 120			
215 e filee tal Hy nt, th	Be	Kerwin Fishe							ldine Lo	,				
21; ould b d Men s mar	P	19a. Informant's Name/Relations			19b. Ma	ailing Addr	ess (Street			mber, City or Town,	, State, Zip Code)			
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Geraldine Hu	nter(Mot	•					Glen Bu		íd. 21061			
re, s l an f Hea If iten		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal fro	20b.	Phace of Dis crematory of	position de la composition del	Name of cem ace)	etery,	Date	20c. Location - 0	City or Town, State			
Page Page nent o		4 Donation 5 Other Sa	_		emoria	al P	ark	1		_	olis, Md.			
Salti ermit. epartu nport ijury		21. Signature of Funeral Service	Licensee	100482					uary, F					
	4	Harry A. 7	- lese							is, Md.				
Physician		23a. Part I. Enter the disease, or failure. List only one cause	on each line.			er the mo	ae or ayıng, s	such as cardi	ac or respiratory an	rest, snock, or near	t Approximate Interval Between Onset and Death			
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Gur								Deali			
	_	Sequentially list conditions,	b		,									
	je.	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause												
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):									
be executed ician and urial - transit	E E		d											
be exe	dical	UNPENDED	AMENDED											
6876(certificate nding phys		IF FEMALE: 23b. Was decedent pregnant in th		utcome of preg	gnancy	Estat day	3	Tetonia pro	an an an	23d. Date of de				
x 68	cial	past 12 months?	1 Live Dil	nu Int at time of de	eath 5	Fetal dea		_Ectopic pre	gnancy	Month	Day Year			
Box 6876 e death certificate the attending phy ed for use as the b	Physi	1 Yes 2 No 9 Unk	nown 9 Unknow	wn										
hat th.	by P	Part II. Other significant conditi	ons contributing to	death but not r	resulting in th	ne underly	ring cause giv	ven in Part I.			ute to the cause of death?			
S, P									_		Probably 4 Unknown			
ord aw rec as bee	blet						autor	a. Was an 24b. Were autopsy findings available prior to completion of cause of						
Rec The I	Completed								1 ✓ Yes		ath? ✔ Yes 2 No			
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that th ars after death. ral Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly	Be	25. Was case referred to medical examiner?	the second second		1			of Death (Che						
Physical diject	의	1 Yes 2 No 27. Manner of Death	28a. Date o	patient 2	28b. Time		DOA 28c. Injury			Residence 6 how injury occurred	Other:			
on of nding Pl. th.	Certification:	1 Natural 5 Pend	ing FOUND:	Day Year)	FOUND:	• •		s 2 V No	Subject sho		'			
isic r Atte er dea recto	icat	2 Accident Inves	tigation Dec 4, 20	010 of Injury - At h	0020 hrs ome, farm, s				28f. Location (Street and Number	or Rural Route Number, City			
Div ras aft	er		not be	Bar/tavern				ū.	or Town, S	State)	ad, Glen Burnie, Md			
Hosp 24 hou Fune rtely fi		29a Certifier	ysician: To the best	of my knowled	ge, death oc	curred at	the time, date	e and place,	and due to the caus	se(s) and manner as	s stated.			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buntal—transition of the completely filled in by the funeral director, page 2 should be detached for use as the buntal—transition of the completely filled in by the funeral director, page 2 should be detached for use as the buntal—transition of the completely filled in by the funeral director, page 2 should be detached for use as the buntal—transition of the completely filled in by the funeral director, page 2 should be detached for use as the buntal—transition of the completely filled in by the funeral director, page 2 should be detached for use as the buntal—transition of the completely filled in by the funeral director, page 2 should be detached for use as the buntal—transition of the completely filled in by the funeral director, page 2 should be detached for use as the buntal—transition of the completely filled in by the funeral director, page 2 should be detached for use as the buntal—transition of the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director of the completely filled in by the funeral director of the completely filled in by the funeral director of the completely filled in by the funeral director of the completely filled in by the funeral director of the completely filled in by the funeral director of the completely filled in the comp	edical		niner:On the basis of and manner sta		and/or investi	igation, in	my opinion, o	death occurre	ed at the time, date	and place, and due	e to the cause(s)			
A F S F O	Ĭ	29b. Signature and title of certifie					29c. License	number		29d. Date signed	(Month, Day, Year)			
NX2		O.C.M.								December 4,	, 2010			
dr.12		30. Name and address of person	•				Dalif	- MD 044	204					
			istant Medical E	xamıner istrar's Signatı		otreet	, Baltimore	e, MD 212	2UT					
Sta Registr	rar	31. Date filed (Month Et. Yor)	2010 2010	nonar s signati	6. 4	back	1							

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State of Manyland / Department of Hoolth and Montal Hydrian.

			For State Registrar		iryland /	Department Certificate			Mental H		2011	0 4169
	Physic Med		1. Decedent's Name (First, Middle, La James Tho	omas	Fari	cell, Sr.			2. Date of Death December 13, 20			3. Time of Death
	Exam		4a. Facility Name (if not institution, give	e street and number)			wn, or Locati	ion of Death			County of De	
	Funera		15 School House 5. Social Security Number 6. S		(In yrs. last b		nsbor				Washing	
	Directo			M 2 □ F	68		rear If Und lays Hour	der 24 Hrs. rs Min.	8. Date of B	Birth Day, Year	942 N	Birthplace (State or Foreig Country) BW York
	yland f shoved at	ţ	10a. State 10b. County		10c. City, To	vn or Location						10d. Inside City Limits
	e Mar r 28a- notifie	Sired	Maryland Washing	gton	Boons	sboro						1 X Yes 2 □ N
	th with th ns 23a o must be	Funeral Director	10e. Street and Number 15 School House (Court		10f. Zip Co 2171				10g. Cit	izen of What 0	Country?
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentai Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ğ	11. Marital Status 1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates.		13. Was Decedent If Yes, specify (Juban, Mexic	can, Puerto	ecify Yes or No Rican, etc.)		14. Race - Am Black, Wh Specify: Wh	ite, etc.
15-	i 72 hc In "na Medic	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	168	a. Decedent's Usual Oo (Give kind of work do	ne dunna m	ost of work	ina	16b. Kii	nd of Busines	s Industry
212	within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5+)		life. DO NOT use reti	red)	OST OF WORK	ing	c,	elf-Emp	loved
pu	e filed Ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)			IIdek bii		ther's Name	e (Fi r st, Middle ,		^	
aryla	ould be nd Men marke marke		Frank Fa 19a. Informant's Name/Relationship (Ty	rrell			Do	oroth	y Way			
e, X	and 2 st Health a tem 27 is		Ginette J. Farrel	1 - Wife		5. Mailing Address (Str. 5. School H	ouse (ber or Rura	al Route Number , Boons	boro,	Town, State, Z , Maryl	ip Code) and 21713
Baltimore,	t. Page tment c rtant: If		1 Burial 2 X Cremation 3 4 Donation 5 Other (Specify	Removal from State	cemete	f Disposition (Name of ry, crematory or other fer Cremat	n/ann)	12/15,	Date / 2010		cation - City or	Town, State Maryland
Bal	Depar Depar Impor any in		21. Signature of Funeral Service License	Hottleme	es	22. Name and Ad Bast-Sta 7606 01d	dress of Faci uffer Natio	Fune:	ral Hom			id. 21713
	Physician/ Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		death. Do r	Con Con	lying, such as	s cardíac o	r respiratory an	rest,	JOIO, M	Approximate Interval Between Onset and Death
	Examiner	ler	Sequentially list conditions,	D. ——————		,.						
	death certificate be executed the attending physician and ad for use as the burial-transit.	(al	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a co								
09		Medical E	resulting in death) Last	Due to (or as a co	nsequence o	f):						
68760	a G a		FEMALE:									
	the death certi	by Physician/	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1 Live Birth 2 4 4 Pregnant at time 9 Unknown	Fetal death	3 Ectopic pregna 5 Other (specify)	ncy			23	d. Date of deli Month	ivery Day Y ear
	requires that the been signed by the hould be detache	d by F	art II. Other significant conditions con	tributing to death but no	ot resulting in	the underlying cause	given in Part	l.				the cause of death?
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Division of Vital Records,	ung ruysklam: ne law requires that the de Affer this certificate has been signed by the funeral director, page 2 should be detached	Completed	. Was case referred to medical						24a. Was au autops perforr	ned?	death?	opsy findings available ompletion of cause of
Vita	is cert direct	99 25 0	examiner?	spital:			Place of Deat		nly one)			
of	fter th	27	. Manner of Death	28a. Date of injury (Month, Day, Year	28b Tir	ne of 28c. Inju	rv at	ursing Home	e 5 Reside	nce 6	Other (Specif	y)
sion	after death, Director: Af Jin by the fur	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M 1 L	ḱ? Yes 2 ☐		d. Describe 110	w injury oc	ccurred	
Division of Vital Reco	ours after eral Direc filled in by		4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	eciry)			Street and Number or Rural Route Number, wn, State)				
the Hos	within 24 hours a To the Funeral D completed filled i	Med L	la. Certifier (Check only one) 3 Certifying Physici Certifying Physici Certifying Nurse Formula Certifier Consideration of the Certifier	an: To the best of my kr : On the basis of examina Practioner: To the best of	iowledge, de ation and/or i f my knowled	ath occured at the tim nvestigation, in my opin lge, death occurred at t	e, date and p on, death oc ne time, date	place, and c curred at the and place, a	due to the caus e time, date and and due to the d	e(s) and m d place, and cause(s) and	nanner as state d due to the ca d manner as st	ed. use(s) and manner stated.
	3 4 2		> Michael	nulin	MI	29c. Licens	e number			d. Date si	gned (Month,	Day, Year)
SH	-10		Name and address of person who com	pleted cause of death (I	tem 23a) (Typ				/mais			in MO
	State Registrar	31.	Date filed (Month Day Year) 6 201	32. Pagistrar's Sig		hours	· v[{ · · ·			102	SCOLA	in MO
						12/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 A^{M} Joseph Fiumara December 5:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Golden Living Center Frederick Social Security Numbe Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 579-16-1739 txxM 2 ☐ F Months Hours $\overset{(Month}{\text{ug}}\overset{Day,}{\text{19}}\overset{\text{Per}}{\text{1}}$ Italy 96 Director Aug Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Hyattsville Maryland Prince Georges XX Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 20782 USA 5924 15th Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White than "natural", Specify Completed 3 🔀 Widowed 4 □ Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) tailoring Tailor marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Paul Fiumara Fortunato Puglisi permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is mark any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21793 8394 Curiosity Court, Walkersville, Maryland Paul Fiumara - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12-20-2010 Silver Spring, Maryland Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Sign wre of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Disense-Immediate Cause (Final MITER Onset and Death ATHERO Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an certificate has b irector, page 2 sh autopsy performe 2 **X**No 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Other: 2 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Dea Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred Natural injury 5 Pending r 24 hours after death be Funeral Director: A cleted filled in by the fi Investigation 2 No Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Numer Frantianian To the death of the cause of (Check within 2

To the I

complex only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) K MK D04795 12-14-2010 MO 30-Name and address of person who completed cause of death (Item 23a) (Type, Print) House-Au-REDERICK 32. Regis r's Signature 31. Date filed (Month, Day, Year) State 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December ^D196 Juanita Luween Gliniak 201o 3:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17808 Woodcrest Road Washington Hagerstown Social Security Number Age (In vrs. last birthday, If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours West Virginia NoV.6, Day 1921 89 Director 215-18-2473 Usual Residence of Decedent show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17808 Woodcrest Road 21740 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Who Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2XXNo Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Homer Morgan Pierce Annalee Strowbridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Hobby - Daughter 17808 Woodcrest Road Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Dec.21,2010 | Hagerstown, Maryland Signatu Funeral Service Osborne Aruneiraliv Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 Approximate Interval Between Inser and Death 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final FNEGIL ψηγοισίαη, disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine MEM SIL the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ s been signal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 s performed 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital 2 - No Other: 잍 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-4 31. Date filed (Month, Day, Year) State Registrar

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	/Medic Examin		4a. Facility Name (If not institution, give street	4b. City, Town, o	r Location of Death	D COGING	4c. County							
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7	Funeral Director		5. Social Security Number 6. Sex 171 − 18 − 4200		e (In yrs 59	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 08 / 03)	r, Year)	Cou	Birthplace (State or Foreign Country)		
			Usual Residence of Decedent						08/03/	(1751		ington, DC		
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36	within 72 hours after death with the Maryland ene. Ithan "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed by Funeral Director		☐ Yes 2 💢 N Yes, Give ear or Dates:	V O		1 ☐ Yes 2 🗓 No	Specify:		Specify	<i>r</i> :	White		
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🖾 Burial 2 □ Cremation 3 🖾 Remov	al from State	C	emetery, cr	ematory or other plac	· .	(/ 0 0 1 0		•	,		
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	*		30. Name and address of person who comple		eath (Item	1 23a) (Type		00 Pennsy				, 'T, -0.0		
			Pauline Daley-Richa				На	gerstown,	MD 217	42				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ars Sígna	ture	A CONTRACTOR							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 Year 105/ AM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Days (Month, Day, Ye 7/9/193 New York **Director** 134-28-3390 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Mary1and Anne Arundel Davidsonville 1 ☐ Yes 2 🖁 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1543 Governor Bridge Rd. 21035 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 X No or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) 12th should be filed within and Mental Hygiene. College (1-4 or 5+) Executive Secretary Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ Martin G. Pisano Mary Ellen Rosetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.s</u> of Health a item 27 i Marcy B. Owens/ Daughter 1543 Governor Bridge Rd., Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 and Department of Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lakemont Cemetery 12/16/10 Davidsonville, MD once Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition Medical hours resulting in death) Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying years Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) signed by the attending physician I be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 Hospital: 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Investigation 6 Could not be Accident filled in by the Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature title of cent 29c. License number D32261 December 13, 2010 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) Richard Feldman, M.D8116 Good Luck Rd., Ste. 300, Lanham, MD 20706 31. Date filed (Month, State sistrar's Signature 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sherri Yvette Griffin-Wright 15/0<u>5</u>%2010 12:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil Elkton Union Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Min 1 □ M 2 🔀 F Months 579-98-5597 47 Yrs. 0971371963 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 ☐ No MD Cecil Elkton 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 19 Berry Ct. 21921 AZU 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 Divorced 4 Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Regional Director of Sales Hotel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ James A. Stone Cordelia Moorman traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau once, 19 Berry Ct., Elkton, MD 21921 <u>John A. Wright Srhusband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Adams UMC Cemetery 15/09/5010 Lothian, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funere Service Licensee 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 Approximate Interval Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ BREAST CARCINAMA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Year Pregnant at time of death Day 1 ☐ Yes 2 y q I I Inknown has been signed by to 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy performe certificate | Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: ဂ္ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) b. A. Mande Di Dao 65733 12/3/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLKTON, MD 21921 126 A E-1764 NARMANA V. PULA smut RA

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, DEC 2 0 2010

3altimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

32. Registrar's signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ 17:17 M Jacob Alan Gerber Medical Secility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death nES Baltimore City 8. Date of Birth (Month, Day, Year) 12/16/1963 Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1**X**) м 2 □ F Washington, DC **Director** 30 96 7243 Yrs. 46 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Chevy Chase 1 XYes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4919 Cumberland Avenue 20815 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Management Consultant Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Trenton Gerber Sandra Shapiro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to <u>Lyndsey Van Vliet/Spouse</u> 4919 Cumberland Ave.. Chevy Chase 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bnai Israel Cong. Cem. 12/14/2010 Oxon Hill, MD 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Fu al Service Licenses 5130 Wisconsin Ave., NW Washington, DC 20016 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death DULMONARY Physician/ embolism disease or condition resulting in death) noun Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the Inneal director, page 2 should be detached for use as the burial-transit completed filled in by the Inneal director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical ブラドレジン リイdの D ivision of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Tes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗷 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗹 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 3 0 D47353 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland Catin Avenue 900

State

Registrar

31. Date filed (Month, Day, Year)

13 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 10:31 Am Norman Bruce Guldan December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Lutherville 408 Kilree Road, #102 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Month, Day, Yes **Funeral** Days Omaha. Hours Year 1 ፟ M 2 ☐ F 577-44-6552 78 Director August Nebraska Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director Lutherville 1 X Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 408 Kilree Road, #102 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. KOREAN 1 ☐ Yes 2 X No Specify: White "natural", 3 Divorced 4 Divorced of Health and Mental Hyglene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bakery Route Salesman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Elizabeth Lindmier Thomas Eugene Guldan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 sl ment of Health a ant: If item 27 is 408 Kilree Road, #102, Lutherville, MD 21093 Lynn K. Guldan / Wife 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/12/2010 George Washington Cemetery Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fureral Service Licensee 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arterosclerotic lever Medical resulting in death) Examiner 060 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine dystroiden that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months? 5 Other (specify) Yes 2 No ed by the a detached t 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requires should peen 24b. Were autopsy findings available prior to completion of cause of death? pulmonaxy disease 24a. Was an autopsy Jas page 2 certificate 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\begin{picture}(100,0) \\ \text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA P 28a. Date of injury 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No М Investigation Accident 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier Doo 358 44 2 10,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roggen Old Court Road 5400 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 3 2010

DHMH 17 Rev 7/2009

Registrar

10-09136 Flavio Garcia

		Registrar			erinicate (oi De	aui				Reg. No.			
Physic Medical Exan							Date of De Month Novembe	Day er 28, 20			Time of Death			
		4a. Facility Name (if not institution 3100 Block of Laurel-		4b. City	y, Town, or L i rel	4c. County Anne Ar								
Funera Directo		5. Social Security Number none	6. Sex	Months Dave							3 / 195		Count	place (State or Foreign try) X 1 C O
v any		Usual Residence of Decedent 10a. State 10b. County			y, Town or Loc		_			,			11	0d. Inside City Limits
Maryland 28a-f show d at once,	ţ	MD Anne Arundel Laurel								Yes 2 XNo				
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number unknown					^{Zip Code} unknc	own		10g. Citizen of What Co				n
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, MD 21215-0036 and 2 should be filed within 72 hours afte lealth and Mental Hygiene. (em 27 is marked other than "natural"; traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12)	College (during	most of v	vorking life. [Loyed	DO NOT us				none		y
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Antonio Garcia Unknown 19a. Informant's Name/Relationship (Type, PDau-in-aw 19b. Mailing Address (Street and Number or Rural Route Number, or Fabiola Dionisio Damian) Fabiola Dionisio Damian 20a. Method of Disposition 1 Surrial 2 Cremation 3 Removal from State Antonio Garcia 20b. Place of Disposition (Name of cemetery, or crematory or other place) San Juanito Cem. 21. Signature of Funeral Serves Licensee 22. Signature of Funeral Serves Licensee 24. Negro and Address (Street and Number or Rural Route Number, or Garcia and Number or Ru									RAL S lver	SERV Spr	ICE ing	,P.A. ,Md20910		
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18760, rificate be executed ing physician and as the burial - transi	edica	UNPENDED	AMENDED											
S E S	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	e 1 Live b	outcome of pre irth ant at time of d	2 F	etal deat		Ectopic p	regnancy	/		Date of de onth	livery Day	Year
Box 6 he death cer the attendi	hysi		9 Unkno							Loo. Bill				
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Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 blours after death. To the Funeral Director: After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for use	Completed									24a. Was auto perfo	psy ormed?	prio dea	r to com	sy findings available pletion of cause of
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Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the:	Certification;	4 Homicide deter	not be	e of Injury - At h	nome, tarm, stre	eet, racto	ery, ornice buil	iding, etc.		or Town, 500 Blk. La				Route Number, City
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3	Ä	29b. Signature and title of certifie	Alla	~		2	9c. License r O.C.M.				1	te signed nber 29		Day, Year)
		30. Name and address of person Carol Allan, MD Ass	who completed caus	•	n 23a) 111 Penn	Street	, Baltimor	e, MD 2	1201			··· - · · · ·		
S	tate	31. Date filed (Month, Day, Year)		gistrar's Signat		200	,					·············		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Wilbur Physician/ December 15, Lee Hunter 2010 9:55 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1131 University Blvd. West, #1501 Montgomery Silver Spring Social Security Number 8. Date of Birth Apr. 15, 1920 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Min. 1**★** M 2 □ F Director 579-14-0511 90 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 🗌 Yes 2 屎 No 10e. Street and Number 10g. Citizen of What Country? Funeral 20902 USA 1131 University Blvd. West, #1501 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ 1 ★ Yes 2 No If Yes, Give 1 Yes 2X No Specify: d Mental Hygiene. marked other than "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates perrit. Page 1 and 2 should be filed within 72 hour Deg attment of Health and Mental Hygene. Important: If item 27 is marked other than "natumy injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Television 4 Broadcast Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Koger Lee Roy Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1131 University Blvd. W., #1501, Silver Spring, MD Audrey P. Hunter/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Dec. 16, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2010 Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licenses MD 20901 23a. Part 1. Enter the disease, or complications that constant the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Head and Neck Cancer disease or condition yrs Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day the i 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hypertension, Benign Prostate Hypertrophy, 1 Tes 2 No 3 Probably 4 Tunknown Completed should High Cholesterol 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed?

Yes 2 No 2 🗆 No 1 🗌 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 😾 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 7/2009

State

completed

29b. Signature and title of certifier

Anuradha Arun, MD 31. Date filed (Month, Day, Year)

16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the within 2

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

82. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

10301 Georgia Avenue, Silver Spring, MD 20902

29d. Date signed (Month, Day, Year)

Dec. 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:25рм Ruth Taylor Hubans December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Manor Care Nursing Home of Bethesda Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09 / 08 / 1928 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min **Director** 176-24-8448 <u>Pennsylvania</u> Usual Residence of Decedent or 28a-f show notified at 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 X No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral P.O. Box 342122 20827 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 X Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working nd Mental Hygiene. marked other than Montgomery County life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Media Specialist Public Schools System Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bartrum J. Taylor Inez Milby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Baxter - Daughter 21034 Forest Highlands Ct., Ashburn, VA 20147 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 12/20/2010 | Brentwood, Maryland . Signature of Funeral Service Licens-e 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. MO#1070 1800 New Hampshire Ave.. Silver Spring. MD 20904 23a. Part 1. Enter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Atherosclerotic Heart Disease Medical resulting in death) Examiner Conjective Heart Failure Sequentially list conditions ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and I for use as the burial-tra Hospital or Attending Physician: The law requires that the death certificate be executed <u> Insulin Dependent - Diabetes</u> that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Yes After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary Hypertension 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an autopsy performed? ☐ Yes 2 🗓 No 1 Yes 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Tes 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending n 24 hours and he Funeral Director: Aft Investigation 1 🗆 Yes 2 🗆 No Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifler X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated **Qertifying Nurse Practioner:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 To the I only one) 29b. Signature and title 2 29c. License number D53691 December 15. 2010 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Ajay Reddy 3200 Tower Oaks Blvd., Suite 110, Rockville, Maryland 20852 M State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State WEND#23b, 23e, 28aperMD, 12/20/10, BMV, MC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Hatim Tufatool Nisa Рм 2010 3:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 2 / 9 / 1 9 6. Sex 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign Country) Guyana **Funeral** 1 D M 2 🖼 F Days 216-19-8613 Director outh America Usual Residence of Decedent show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Silver Spring XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12704 Rigdale Terrace 20904 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🕱 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: East Indian Completed 3 X Widowed 4 Divorced Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 6 Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mohammed Edun Hadra Baksh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 Bibi S. Hatim -daughter 12340 Sandy Point Ct. Silver Spring, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 12/12/10 Maryland National Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Universal Mortuary 411 Kennedy St NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ cnti (Fr da disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 20.cm Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit Exami The law requires that the death certificate be executed chure that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical mound Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death signed by the a d be detached f g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? page performed 2 No Yes 2 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 1 Other: 1 Yes မ 1 Sepatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director. After this bempleted filled in by the funeral of 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 27366 ARVIND M. Mehta, M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Collec # we 509 1100 31. Date filed (Month, Day, Year) Registrar's Signat State DEC 16 Registrar

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier





10+1

Saltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

29c. License number

D-17874

29d. Date signed (Month, Day, Year)

December 8, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 December 10:59 PM Chung Soo Han Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park . Social Security Number 8. Date of Birth (Month, Day, Yea Sept 28, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗍 F Months Days Hours Min. 218-76-1584 Korea Director Sept. 1943 67 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Derwood 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7708 Warbler Lane 20855 United States "natural", or items 11 Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Force Black, White, etc. ۾ 1 X Never Married 2 ☐ Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed 3 Divorced 4 Divorced Asian Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental H item 27 is marked or ည Dong S. Han E.S. Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7708 Warbler Lane, Derwood, Maryland 20855 Chang Y. Han (Brother) other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1. Department of I Important: If it any injury or of cemetery crematory or other place)
Norheck
Memorial Park 1 X Burial 2 Cremation 3 Removal from State December 11 4 Donation 5 Other (Specify) 2010 Olney, Maryland 21. Signature of Funeral Ser 22. Name and Address of Facility DeVol Funeral Home, M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 23 . Part Frier the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, if hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Non Ischemic Cardiomyopathy disease or condition Months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Cause (Disease or iinjury that initiated events death certificate be executed Due to (or as a consequence of): resulting in death) Last bunialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death 1 Yes 2 L 9 Unknown ed by the a detached t g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Physician; The performed this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes _2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death e Hospital or Attending Pt 124 hours after death. E Funeral Director; After the leted filled in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending Accident 1 Tyes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours a the Funeral D Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tille of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and addrese

DEC

18

James L. Cock

Cockrell, Jr., M.D., 7901 Maple Avenue, Takoma Park, MD 20912

of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signat

14

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 18:50 M Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Anne Arunde Arunde 7. Age (In yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Min. (Month, Day, Director Usual Residence of Decedent Allo bord Mental Hygiene.

In marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other marked or items and the motified at or items 23a or 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconda/ (0-42) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19b. Mailing Address (Street and Nu mone Hammettimother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12/13/2010 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subsete \text{No} \) Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe funeral director, page 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes Accident 2 No s after death Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifler 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rindfleisen Annapolis, Md Medical Pkny 2001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 1,2010 Edwin Lee Howard 7:21 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Severna Park Anne Arundel Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Hours Min 0297577979 ost Texas 453-12-7852 91 Director Usual Residence of Deceden 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** MD Anne Arundel Severna Park 1 ☐ Yes 2 🕅 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 43 West McKinsey Road 21146 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, vvas Decedent Ever in U.S Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X ☐ No Specify: Specify: White Completed 3 √ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Navy 12 04 Aeronautical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I important: If item 27 is marked o any injury or other traumatic eve once. Elmer Lee Howard Bessie E. Kuvkendall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Ashlin Daughter 1466 Blockton Court Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12/13/2010 Glen Burnie, MD Signature of Fun Service License 22. Name and Address of Facility ali Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Meay 4 Kity disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed's death? 1 ☐ Yes 2 ☐ No 2 Yes 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 XX Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 🗌 Yes 2 🗌 No s after death filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D004051 12-13-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Nuisairee M.D. 1401 Madison Park Place Glen Burnie, MD 21061 31. Date filed (Month, Day, Year, State DEC 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth Hasko DECEMBEZ II 2010 2.50 (Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAGIMERE WASHINGTON MEDICAL CENTE BUZNIE GLEH ANNE THUISP. . Social Security Number 8. Date of Birth
(Month, Day, Year)
NOV • 18,1927 7. Age (In yrs. last birthday) 83 Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🂢 F Director 192-20-5676 West Virginia Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 54 Magothy Beach Road 21122 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Retail/Service 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Bencze Joseph Magyar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1105 Bellevista Court Severna Park, MD 21146 Patricia Bisciotti/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lansdale Crematory December 20c. Location - City or Town, State TASCO 1 Burial 2 X Cremation 3 Removal from State Lansdale, PA 4 Donation 5 Other (Specify) 2010 . Signature of Euneral Service Licensee Barranco & Sons, P.A. 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 23a. Hart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death h sician/ CEREBRO VASCUL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Tes 2 🗹 No Other: 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation
Could not be within 24 hours after death To the Funeral Director, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 | 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 45149 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gleu Burnie Mi) Horaira 31. Date filed (Month 32/Registrar's State 15 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 December 9:45P Dale Alan Hall Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min 69 Hours 2/12/1941 Director Mary Land 217-40-8970 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Marvland Anne Arundel Odenton 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 8607 Wintergreen Court Unit 402 21113 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? 1963 Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify. item 27 is marked other than "natural", other traumatic event, the Medical Exa 1969 3 Widowed 4 N Divorced Specify: Completed White Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CEO/CFO O.T. Hall & Son. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0wen Hall Α. Florence R. Mosebrook permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Susan Hall/Former Spouse 1108 Brassie Court, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemetery 12/10/2010 Davidsonville, MD 21. Signature Funeral Service Linesee 22. Name and Address of Facility George P. Kalas Funeral Home all 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Par 1. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) MELANOM Medical Due to (or as a consequence o Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a do resquence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranresulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a ld be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 🚰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 0065 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravin Garg, M.D. 2001 Medical Parkway, Annapolis, MD 21401 31. Date filed (Month EC 0 8 2010 egistrar's Signatur State Registrar

State of Maryland / Department of Health and Mental Hygiene 2010 4 7 1 3 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ZO/ O 1316 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Anne Arundel Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 ☑ F Days May 22 54 ^{ea} 1956 Maryland 217-58-1889 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 🕅 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1569 Ritchie Lane 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. , or Black, White, etc. 1 Never Married 2X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: should be filed within 72 hours afti and Mental Hygiene. 'is marked other than "natural", **Black** 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important. If item 27 is marked other than "naturally injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Crownsville Elementary/Seconday (0-12) 12th College (1-4 or 5+) Nurse Aid State Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene Slocum Alice Gantt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William S. Hall Sr(Husband) 1569 Ritchie Lane Annapolis, Md. 21401 20a. Method of Disposition 20b. Besitospastice (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Memorial Park 12-7-10 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) W Marne a Ranse of Pacility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 m0048 Beese 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Approximate Interval Between Onsat and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami burial-transit and Due to (or as a consequence of physician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending injury 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier ame and address of pelson will completed cause of death (Item 23a) (Type, Print) ICH AR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended#1, 12/16/10, M.S. Kent Co. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Lest) Dey Year David Hank Henkensiefken Month 1400 **Physician** 2010 12 deapen is at few /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Name (If not institution, give street end number) Examiner Hours Min. B. Date of Birth (Month Dey, Yeer) 4 - 8 - 1 9 5 3 HOGPILL OF QUEEN Arre's Mospie Cont Birthplace (State or Foreign Country)
 MD If Under 1 Year 7. Age (In yrs. lest birthday)
57 vrs 6. Sex 11 M 2□ F 5. Social Security Number **Funeral** Days Months 220-58-2057 Director Usuel Residence of Decedent 10d. Inside City Limits with the Merylend 10c. City, Town or Location 10a. Stete 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD Oueen Anne's Centreville 1 ☐ Yes 2 No Director 10f. Zip Code 21617 10g. Citizen of What Country? 10e. Street end Number 241 Burrisville Road USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes ≥ ∑XNo If Yes, Give Year or Detes: 11 Marital Status filed within 72 hours efter 1 Driveyer Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify. Specify: White Baltimore, Maryland 21215-0020 2 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 end 2 should be filed within 7 Depertment of Health end Mental Hygiene. Important: If Item 27 is merked other than "na any Injury or other trainment. College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Construction 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Virginia Cox John Calvin Henkensiefken 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirley Ford Sister 241 Burrisville Road Centreville ,MD 21617 20c. Location - City or Town, State 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 717 W.Divisior 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Direct Crematory, LLC 12/15/2010 Dover, DE 19904 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Bennie Smith Funeral Home 855 High Street Chestertown, MD 21620 23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical GTALE monny LIVER Examinet Due to (or as a consequence of): Examiner ed by the attending physician end deteched for use es the bunel-trensit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No sete hes been signed by page 2 should be detected ģ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Tyes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 St Other (Specify) Floshic Care 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifics completely filled in by the funeral director, in

6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature end title of cartifier JEFEREY VILLAS M

21617

29c. License number

29d. Date signed (Month, Day, Yeer) 13/10

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

2540 co-Trentle Rom

31. Date filed (Month, Day, Yeer) 32. Registra s Signeture DEC 18

Medical

State

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kestel T. Huffman Physician/ Dav Month Year December 2010 Medical :28 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 NC **Funeral** Days Hours Min. 1 X M 2 A F Months June 30, Year 1930 242-40-3310 80 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be Funeral 12707 Flack Street 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, med Forces Black, White, etc þ 1 Never Married 2 Married 1 x Yes 2 □ No If Yes, Give Korean Year or Dates.Conflict 1 ☐ Yes 2 A No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Police Officer Metropolitan Police Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ Kestel Tyree Huffman, Sr. Doris Hawkins injury or other traumatic 19a. Informant's Name/Relationship (Type, Prin 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12707 Flack Street, Silver Spring, MD 20906 permit. Page 1 and 2 sk Department of Health ar Important: If item 27 is any injury or other trau Mariane B. Huffman/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. 1: 2010 15 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical the attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) the g 🗌 Unknown g Unknown ed by the signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4x Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 XNo 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

of To the Hospital or Attending Division thin 24 hours after death.
the Funeral Director: After mpleted filled in by the fun within 2 To the

Maryland 21215-0036

Baltimore,

68760

Box

P.0.

Records,

Vital

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

Bindu Joseph, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Drive, Rockville, MD 20850

D60634

29d, Date signed (Month, Day, Year)

Dec. 10, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 08 Physician/ 12:04рм Carl С. Huber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 X M 2 □ F **Funeral** Months Hours Min Month Day Year 40 Pennsylvania Director 70 179-32-3313 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director 10c. City. Town or Location 1 Yes 2 X No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 U.S.A. 4909 Walkingfern Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give 1 Never Married 2 X Married δ 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed Year or Dates. Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Labor Union Official Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carl C. Huber Margaret Anne Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4909 Walkingfern Drive, Rockville, Maryland 20853 Barbara M. Huber - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Page 1 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 12/13/2010 Brentwood, Maryland 21. Sign turn of Huner | Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Cal 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ pneumonia disease or condition resulting in death) Medical e to (or as a consequence of): Examiner cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (of as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the ard d be detached for 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has rai director, page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 2 No မ 1 🗌 Yes 1 Marient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injurv 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) in DOD 65505 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical center Drive, Rockville, Maryland 20850 Cheng, MD Quitang 9901 31. Date filed (Month, Day, Year) Registrar's Signatur State 13 Registrar

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DECEMBE

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12: 1 Yes 2 9 Unknown	months? ☐ No	23		ve Birth egnant a		Ideath 3	Ectopic Other (s _i		у			23d. Date Mon	e of delive	ry Day	Year
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Viti To Con		29b. Signature and	title of certifie		0					c. License	number		-	Date signed			
0H-371		30. Name and addre	T DA							5-7	HAG	ERS	10 W	~ ~	\0	217	No
State Registra		31. Date filed (Mont	th, Day, Year) DEC 1.7	7 30		. Pegistra	ar's Signat	ture	mark.	,							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day 14:42p_M **Physician** Brian Lee Henson Dec. 13 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11915 Cove Road Clear Spring Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **™** M 2□ F 217-74-6527 52 Director 7-7-1958 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f show (Exeminer nust be notified at MD Washington Clear Spring 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or items any injury or other traumatic event, the Medical Examinar must be a since. 11915 Cove Road 21722 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) plastic mfg. co Elementary/Secondary (0-12) College (1-4or 5+) machinest 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roberta L. Weaver Leonard L. Henson ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11915 Cove Road Clear Spring, MD 21722 Rebecca Henson spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crem. 1 ☐ Burial 2 【*** Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc
P.O.BOX 310 Clear Spring, MD 21722
Approximate 21. Signature of Funeral Service License Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a, Part 1. shock, or heart failure. List only one cause on each ine Immediate Cause (Final disease or condition resulting in death) enler **Physician** /Medical Due to (or as a consequency of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 □ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number eted cause of death (Item 23a) (Type, Print) IN ms 11110 midical Cangu 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 Registrar

DHMH 17 Rev 1/2001

HAWKINS, SHANEKA N.

				ype or Print in E State of Maryland					=	_	
		-	For State Registrar	- Claro or Maryland			of Death			Reg. No.	41720
	Physicia Medic		1. Decedent's Name (First, Middle, Last) SHANEKA NICOLE HAWK	KINS					2. Date of Dea Month ECEMB	Day Year	3. Time of Death
	Examin	er	4a. Facility Name (if not institution, give str Q I VISTA MEDICAL	1		, 10	own, or Location of	of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. las	st birthday) Yrs.	If Under 1			8. Date of Birth	9. Bi	rthplace (State or Foreign
	and show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Loc	ation					10d. Inside City Limits
	e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	MARYLAND CHARLES 10e. Street and Number	IAW	LDORF	104 75- 0					1 X Yes 2 □ No
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Maryland	ould be filed nd Mental Hy marked oth I matic event	To Be	17. Father's Name (First, Middle, Last) WARREN EVERETT HAWK	CINS						Maiden Surname) ISON HAWKIN	IS
	2 sh th ar th ar trau		19a. Informant's Name/Relationship (Type CYNTHIA A. HAWKINS							City or Town, State, Z	
Baltimore,	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1	emoval from State ce	ace of Dispos metery, crem PELER'S	atory or other	of er place) CEMETERY	DEC. 1		20c. Location - City o	
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours all er delith. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled by the funeral director, page 2 should be detached for use as the	Completed							24a. Was a autops perfor	sy prior to med? / death?	utopsy findings available completion of cause of
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	ne Hospi n 24 hou ne Funer pleted fill	Medical	(Check 2 Medical Examine)	ian: To the best of my knowle r: On the basis of examination Practioner: To the best of my	and/or investi	gation, in my	opinion, death of	ccurred at the	ne time, date an	id place, and due to the	cause(s) and manner stated.
	Vithi To th		29b. Signature and title of certifier			29c. L	icense number	11	2	29d. Date signed (Mon	th, Day, Year)
	01		30. Name and address of person who com	npleted cause of death (Item	23a) (Type, Pr	int)	457	31		12/11/	10
1	BI			AUANTHAN M	10 3	3786	LD WAS	HING	TON R	D WALDOR	F, MD 20602
	Stat Registra		DEC 1 4 201	32. Registrar's Signatu	2. Apa	West of					

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 10, 2010 1520 hrs_M Blair Eugene Hogan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick [] Mt Airy Kline Hospice House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1XXM 2 ... Months Days Hours Min. July 1, 1930 80 ennsylvania 723-07-8989 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Mt. Airy Maryland Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21771 1 Warfield Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: white Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Railroad 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William F. Hogan Florence B. Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cleora A. Hogan - wife 1 Warfield Drive, Mt. Airy, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 12-16-2010 Mt. Airy, Maryland 4 Donation 5 Other (Specify) Pine Grove Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 LU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, ner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s . Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Director: After this certificate 1 Yes 2 No Yes 2 N completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one, examiner? Hospital: 1 Yes 2 410 Other: 6 X Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 13/10 address of person who completed cause of death (Item 23a) (Type, Print) chuson Maneis Drug 01 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DEC. 1 2 ay 2010 JAMES RONALD HOARD, JR. 3:04A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY 15469 BARNESVILLE ROAD BOYDS If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 1 M 2 □ F Country) 63 Director 313-52-2244 1947 INUsual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. Count 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No MD MONTGOMERY BOYDS 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral must 15469 BARNESVILLE ROAD 20841 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No1 96
If Yes, Give 1970 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married 2 No1 968-ve 1970 filed within 72 hours after al Hygiene. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the t. Page 1 and 2 should be filed within trent of Health and Mental Hygiens rrant: If item 27 is marked other thiury or other traumatic event, the BUSINESS OWNER INSURANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JAMES RONALD HOARD, SR. MARY ELLEN WINN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48505 JANICE HAMLIN / SISTER 6802 ORANGE LANE, FLINT, MICHIGAN 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place. Department of Important: If any injury or once. STAUFFER CREMATORY 12/15/2010 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sirvice Licen 22. Name and Address of Facility P.O. BOX 86 BARNESVILLE, HILTON FUNERAL HOME 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one call Interval Between Immediate Cause (Final Onset and Death Ph sician/ Sorra disease or condition resulting in death) 180,5 Medical Due to (or is a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ner o (or as a consequ Examir the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown detached Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No this certificate Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 🗌 No 1 Yes ပ္ 4 ☐ Nursing Home 5- Residence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurr After 1, Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1900 0} 2004 1 Yes Investigation after death Director: / the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City; or Town, State) completed filled in by determined building, etc. <u>چ</u> 24 hours 81200 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Signature and title of certific 29c. License number 2010 mopme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4tlUA mO MOY 31. Date filed (Month, Day, Year) ar's Signature State 32. Regist DE KNESSA Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. 1020 Gertrude Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Nicomico Poninsula Raylomal Medical Center rusbur If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Cour Wash DC **Funeral** 8. Date of Birth Days Min 7 -M391th- P=9 2041) 579-22-4569 86 Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Berlin MD Worcester 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11436 Gum Point Road 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify. If Yes, Give Year or Dates 3X Widowed 4 □ Divorced Specify. white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done duning most of working life, DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Home Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oths any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Antonino Pedone Gertrude Pedone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Howard-Daughter 601 Dory Road #3 Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place First State Crem. 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State 12-13-10 4 ☐ Donation 5 ☐ Other (Specify) Millsboro, DE Signa of Funeral Service 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ STUPE OF THERE ANOURYEM disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): AURTIC ANEURYEN HOLACK Sequentially list conditions Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy5 ☐ Other (specify) Pregnant at time of death Month Dav Year After this certificate has been signed by the infuneral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No Yes 2 No 1 Tes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 2 X No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрыет (Check Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only on Setylifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 5355 10,2010 30. Name and address son who completed cause of death (Item 23a) (Type, Print) BA3 MO100 James Camo loda rect

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month E. Itnyre 10:50 M Roy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 8. Date of Birth (Month, Day, Year) Mar 20, 1947 Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 219-44-3399 1**X** M 2 □ F 63 West Virginia Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No Sharpsburg Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21782 Funeral 4537 Harpers Ferry Road U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2x No Specify: 3 Divorced White Specify: Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufactureer of Rain Wear London Fog Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Louise Tucker Thurston Elwood Itnyre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4537 Harpers Ferry Road, Sharpsburg, Maryland 21782 Shelia E. Itnyre - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Cedar Lawn Mem. Pk. 12/24/2010 Hagerstown, Maryland 21. Signature of Funeral Service License 28 Agread Admiffe Filt Tuneral Home, P.A. 7606 Old National Pike, Boonsboro, Md. 21783 Donald C. tottle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailuve Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Pyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy After this certificate 2 🗌 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifie M.D. 30. Name and address of person who complete completed ause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

OPAL CT. HAGET-STOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 20:59 M Tecin Innocent 2010 12 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore, Maryland Maryland 0 niversity If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days 1 🔀 M 2 🗆 F Months Hours JUNE 24 .19<u>28</u> Country) HAITI Director 82 NONE Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location pemit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Ty Yes 2 No BRENTWOOD PRINCE GEORGES 10e Street and Number 10f. Zin Code 10a. Citizen of What Country? Funeral HAITI 20722 3802 UPSHUR ST. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes. Give 3 Widowed 4 Divorced Year or Dates BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SHOES SHOEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNK. CINELIA **EVELLARD** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3802 UPSHUR ST., BRENTWOOD, CARLO CAMILLE/NEPHEW MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12-13-2010 CHAMBERS CREMATORY RIVERDALE, MD. 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 21. Signature of Funeral Service Licenses RIVERDALE, MD CLEVELAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Thrombocytopenic Inrombotic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🙇 Natural 5 Pending work 1 🗆 Yes 2 🗆 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

Registrar
DHMH 17 Rev 7/2009

State

Rebicca

31. Date filed (Month, Day, Year,

13

South

MD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1700011632

Greene St., BALTIMORE, MD. 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 201 0 Physician/ DECEMBER 3:12 A **JENKINS** R. BEVERLY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** AUG 27 Days 1 🗆 M 2 🛣 F Hours WASHINGTON, DC 1946 64 Yrs. Director 577-64-2344 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 😾 Yes 2 🗆 No PRINCE GEORGE'S CAPITOL HEIGHTS MD 10g. Citizen of What Country? 10e. Street and Numbe Funeral 20743 USA 7313 CALDER DRIVE death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black White etc. 1 Never Married 2 Married 1 Yes 2 X No þ hours after Maryland 21215-0036 BLACK 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) within 72 al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) NONE DISABLED 12TH Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic ever မ MARGARET HAWKINS permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 6 JOHN THOMAS HAWKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CALDER DRIVE CAPITOL HEIGHTS, MARYLAND 20785 DENISE R. CLARKE/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 12/13/2010 CLINTON, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 allo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) END STAGE RENAL DISEASE Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS TYPE 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of: Examin Cause (Disease or iinjury MULTIPLE UNSTAGEABLE PRESSURE ULCERS and tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BILATERAL LOWER EXTREMITY DVT, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 ⊌nknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 1 Yes 2 No certificate : Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation the 1 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2. 3 only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 081 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA SUPANICH M.D. 1500 FOREST GLEN ROAD #727 SILVER SPRING, MARYLAND 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death DECEMBER Day 9 2010 Physician/ 3:20 P M JACKSON AUNDREA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** MAY 22 1 □ M 2 🗓 F Months Days Hours MARYLAND T965 45 Director 055-58-3720 Usual Residence of Decedent shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 □xYes 2 □ No KINGS BROOKLYN NY10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 11206 USA 109 LEWIS AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc þ 1 Never Married 2 X Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) NONE NONE 12TH Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ PHOZIA NELSON BENJAMIN JACKSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2933 MOZART DRIVE SILVER SPRING, MARYLAND 20904 SINCLAIR/SISTER PATRICIA . Page 1 and 2 s tment of Health 27 : If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/15/2010 LINDEN, NEW JERSEY ROSE HILL CEMETERY Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) CARDIAC ARREST Medical Examiner ENDOCARDITIS Sequentially list conditions Examine Due to (or as a consequence or, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury BACTEREMIA attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the a q 🗌 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown STAGE IV CERVICAL CANCER plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed Yes 2 X 1 ☐ Yes 2X☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 XNo 1 ₺ Inpatient 2 □ ER/Outpatient 3 □ DOA 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ျ this nin 24 hours after death.

the Funeral Director: After thi

mpleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Pyes 2 No 1 X Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi-D67589 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 LAWSON M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND HAROLD V. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

		1	For State Registrar	state of Marylar		tificate of D			Reg. No.		
	BL		Decedent's Name (First, Middle, Last)					2. Date of De	ath	Year	3. Time of Death
	Physicia Medic	al .	William Edward Kni					12/0	5/2010		6:00 p ^M
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	n with	nera	12017 Steven Lane			207				ed Sta	
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920	safter ral", o Exam	q pe	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates.	1	Yes 2 🔀 No	Specify:		Spe	^{cify:} Whi	ite
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az	should and N is ma auma		19a. Informant's Name/Relationship (Type,	Print)	1	ng Address (Street a					Code)
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Baltimore,	permit. Page 1 Department of Important: If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	1201		morial Gard Name and Addres					vert, P.A.
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Division of Vital Records,	tal or as after al Direction be		4 - Horrisolde determined	building, etc. (Spec	ity) 			City or To	wn, State)		
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	To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	M	only one) 3 Certifying Nurse F 29b. Signature and ittle of certifier	Practioner: To the best of	my knowledge,	death occurred at the	e time, date and pla	ce, and due to t	he cause(s) ar	d manner as igned (Month	stated.
	F ≥ F ŏ		1 Kush			MD 1			12	71	010
				pleted cause of death (Ite		Print)				<u> </u>	
Дf	SM 10		Kenneth Lee, M.D.			W, Ste. 3	15, Wash	ington,	DC 20	006	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra s Sign	nature	backer	,				

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Examin	er	4a. Facility Name (If not institution, give street and number) Rockville Nursing Home		4b. City, Town, or Rockvil	Location of Death 1e		4c. County Mont g	of Death gomery	7
Funeral Director		073-18-3173 1 □ M 2 🛣 F	e (In yrs. last birthday) 99 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 10/09/1	h , Year) 911	Count	olace (State or Foreign try) ece
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perintificates, Maryjaring Z.I.Z.13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mertal Hygiene. Important: If time Z7 is amended other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ▼ If Yes, Give Year or Dates.	No	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🌠 No	spanic Origin? (Spanic Origin?) n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	e - America ok, White, e : Whit	etc.
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Dealtillor Dearmit. Page 1 Department of Important: If is any injury or of	10	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Ft. Linco	1n Cemeto . Name and Addres			Brentw ler's So		
		William R. Bugge		130 Wisco					
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and certificate be executed attending physician and for use as the burial-transit	edical Examiner	that initiated events C. ———————————————————————————————————	consequence of);						
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To the within Congression		29b. Signature and title of certifier WIWWS V. G	sopr	29c. License D0047			29d. Date signe 12/10/		Day, Year)
		$30.$ Name and address of person who completed cause of de $Thomas\ V.\ Joseph\ MD\ 50\ W.\ H$	ath (Item 23a) (Type, P Edmonston I	Or. #207	Rockville	e, MD 20)852		
Stat Registra		31. Date filed (Month, Day, Year) DEC 15 2010	r's Signature	W.					

Date

22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria

20c. Location - City or Town, State

Upper Marlboro, MD

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. Baltimore, Maryland 21215-0036

Physician/

Medical

10a. State

Director

Funeral

Completed by

Be

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20a. Method of Disposition

1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Examiner

Funeral

Director

Physician Medical Examiner

> attending physician and for use as the burial-tran page 2 s after deat Director:

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

within 24 ho

To the Fune

	23a. Part 1. Enter the disease, or composhock, or heart failure. List only on	a married and a male black					Approximate Interval Between
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บั	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)		
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cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	b. Time of injury M	28c. Injury at work?	28d. Describe how inju		
500	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, facto	pry, office	28f. Location (Street a City or Town, Sta		Route Number,
Medica	(Check 2 Medical Examin	cian: To the best of my knowledger: On the basis of examination and Practioner: To the best of my kn	nd/or investigation, li	n my opinion, death occurred	at the time, date and place	ce, and due to the cau	se(s) and manner stated.
-	29b. Signature and title of certifier	~	u 29	C License number	15 DE	Date signed (Month, D	Day, Year)
	30. Name and oddress of person who co	ompleted cause of death (Item 23	a) (Type, Print)	D 1854	WEN WA	4630651	ud. 2000

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Episcopal Cemetery Dec 16, 2010

Ferry Road, Clinton, MD 20735

State Registrar

23

Year) 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sophie Lachin 2010 10:19 AM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year)
Dec. 25, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 207-16-5452 1 M 2 X F Months Days Hours Min. Pennsylvania 1923 Director 86 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at Director Rockville Maryland Montgomery 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 United States 13409 Keating Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 XWidowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even onee. and Mental F မ Jack Kirkorian Marian Azadian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13409 Keating Street, Rockville, MD 20853 Mitchell Charles Lachin (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 17 cemetery, crematory or other place)
Parklawn
Memorial Park 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2010 Rockville, Maryland 21. Signature of Funeral 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 Part In Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Year Month Day 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Certificate: To Be Other (Specify) occurred

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. completed filled in by the funeral director,

28a-f shov

"natural",

al Hygiene.

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

						performed?					
. Was case referred to medical		26. Place of Death (Check only one)									
examiner? 1 Yes 2 No	Hos	spital: 1 🗌 Inpatient 2 🖃	Home 5 ☐ Residence 6								
. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury					
	Could not be	28e. Place of Injury - At he building, etc. (Specify		t, facto	ory, office	28f. Location (Street and City or Town, State)					
Contision 1 Contistuing Plan	reinir	ame To the heat of my know	ledge death oc	cured	at the time date and place :	and due to the cause(s) and					

med Air

29 (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number

10050110

Number or Rural Route Number.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Porner Philip Dr. MD 32 Registrar's Signat

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 732 amend #30 Per PHY G911 1707/2011 JH
State of Maryland / Department of Health and Mental Hygiene

		٠	1 - For State Registra MEND#8 perFH.	2/27/10 FMW MCC	Cei	rtificate of I	Death	viorital i i	Reg. N	0	
	Physicia Medic		Decedent's Name (First, Middle, La Mazella Hamilton	ist)	<u> </u>			2. Date of De Month Dec. 10,	ath		3. Time of Death 2:30 p M
	Examin		4a. Facility Name (if not institution, giv				r Location of Death			c. County of Deat	
تعمي	<u></u>		3602 Edelmar Terra 5. Social Security Number 6.		(Silver	Spring If Under 24 Hrs.	T		Montgomery	
ı	Funeral Director		217-28-7831	Sex 7. Age (In yrs. 1 ☐ M 2 🛣 F 98		Months Days	Hours Min.	8. Date of Bir (Month, Pa Sept • 1	Year) 19	9. Birt Cou	hplace (State or Foreign intry) DC
	and show 1 at	or	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Maryl 28a-f otifiec	irect		tgomery	Silver S	Spring					1 Yes 2 No
	with the 23a or ust be n	Funeral Director	10e. Street and Number 3602 Edelmar Terra	ce		10f. Zip Code 20906			10g. C	itizen of What Co	untry?
036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify white	, etc.
ب ک	2 hour "natur	plete	15. Decedent's (Specify only highest g	Education	16a. Deced	dent's Usual Occup	pation during most of work	kina	16b. i	Kind of Business I	ndustry
127	vithin 73 iene. rr than the Me	Com	Elementary/Seconday (0-12)	ung	Fed	eral Gover	mment				
Maryland 21215-0036	ild be filed w Mental Hyg arked othe iatic event,	To Be	17. Father's Name (First, Middle, Last) Janes T. Hamilton				18. Mother's Nan Mazella Mo		Maiden	Surname)	
, Mar	s 1 and 2 should be of Health and Ments of item 27 is marked r other traumatic e		19a. Informant's Name/Relationship (Dorothy L. Herringtor		1	-	and Number or Rui eed Court,				Code)
saltimore,	permit. Page 1 are Department of H Important: If itel any injury or ott		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Spec	Removal from State	Place of Dispo cemetery, crem lar HIII	osition (Name of matory or other plac Ceme tery	Dec. 20	Date 16 10		cocation - City or	Town, State
Ball	permit Depari Impor any in		21. Signatur Funeral Service Licer	Cle	50 50	Name and Addre rancis J. O Universi	ss of Facility Collins Fur ty Blvd. W	neral Home , Silver	Spri	ng, MD 209	901
	hysician/	W 1	23a. Part 1. Enter the disease, or don shock, or heart failure. List only Immediate Cause (Final disease or condition	pications that caused the dea cause on each line. Sepsis	ath. Do not ente	er the mode of dyir	ig, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consec							
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2	rificate be executed ing physician and as the burial- unsit.	Medical Examiner	resulting in death) Last	Due to (or as a consect	quence ot):						
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POX 0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-u-nist	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of g ☐ Unknown	tal death 3	Ectopic pregnand Other (specify)	су			23d. Date of deli Month	very Day Year
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VITA	sician certifi rector	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	-	Oth	ace of Death (Chec				
N 10 L	iding Phys th. After this funeral di	cate: To	27. Manner of Death 1 🙀 Natural 5 🗆 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur	4 ∐ Nursing H y at	ome 5 LyResion 28d. Describe h		6 Other (Special ry occurred	(y)
DIVISION	al or Atten s after dea il Director: ed in by the	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not 4 Homicide determined	De Place of Injury At h	nome, farm, stre fy)		103 2 110	28f. Location (S City or Tow		nd Number or Run e)	al Route Number,
	he Hospit in 24 hour he Funera ipleted filk	Medical	(Check 2 L Medical Exan	vsician: To the best of my know niner: On the basis of examinationse Practioner: To the best of n	on and/or invest	tigation, in my opinio	on, death occurred a	t the time, date a	nd place	e, and due to the c	ause(s) and manner stated.
	_		29b. Signature and title of certifier	10.00		29c. License	e number			te signed (Month,	
	10		30. Name and address of person who	m My	ni 21 a) (Tyne D	Print)				Dec. 15, 2	.010
			James Rossi, MD 330	5 N. Leisure Word	ll Blvd.	Silver Spr	ing ,MD 209	906			
	Stat Registra		31. Date filed (Month, Day, Year) NFC: 1 5 20	37. Registrar's Signa	ature for	de					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	Otate of Ma	•	Certificate of E			Reg. No.		_
Physi Me	cian/ edica	7	1. Decedent's Name (First, Midd Edith)	lle, Last) Leonard				2. Date of Dea Month December	D <u>a</u> y	Year 2010	3. Time of Death
Exar				Maryland Med	tical Cent	er Balt	Location of Death			ounty of Death	
Funer Direct	_		5. Social Security Number 206–20–8566	6. Sex 7. Age 1 M 2 XF	(In yrs. last birthd 86 Yr	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 2/28/2	th y, Year) .4	9. Birth Cour	place (State or Foreign htry) MD
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuny or other traumatic event, the Medical Examiner must be notified at	Director	_ -	Jsual Residence of Decedent 10a. State 10b. Count MD Anne 10e. Street and Number	Arundel	10c. City, Town o	Annapolis 10f. Zip Code			10a Citiz	en of What Cou	10d. Inside City Limits 1 Yes 2 No
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0036 urs after deat tural", or iter	tod by E	\$	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 🏿 Widowed 4 ☐ Divorce	ed If Yes, Give Year or Dates.	lo	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√√No	Specify:	oecify Yes or No- o Rican, etc.)	Sı	4. Race - Americ Black, White, pecify: Whi	etc. Le
21215-0036 within 72 hours after giene. ner than "natural", o	potolamo	-		ent's Education hest grade completed) College (1-4 or 5+	(0	ecedent's Usual Occup Rive kind of work done on E. DO NOT use retired)	during most of wor	king	16b. Kind	d of Business In	
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Ma nd 2 sho lealth an m 27 is			Sandra Gewante		623	4 Woodcres		Baltimor	e. MI	21209	
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Balti permit. Departr Importa	ouce.		21. Signature of Funeral Service	Licensee		22. Name and Addres Hardesty Fi		ome P.A.	12 F	Ridgely	
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Division and the rest after de al Directo ed in by the	i to C		3 ☐ Suicide 6 ☐ Coul 4 ☐ Homícide deter	d not be mined 28e. Place of Injury building, etc.		, street, factory, office		28f. Location (S City or Tow		Number or Rura	l Route Number,
ne Hospit n 24 hour ne Funera	Modical	Medice	(Check 2 Medical	ng Physician: To the best of m Examiner: On the basis of exa ng Nurse Practioner: To the b	amination and/or i	rvestigation, in my opinio	on, death occurred	at the time, date a	and place, a	ind due to the ca	use(s) and manner stated.
To the within commendation			29b. Signature and title of certification of the signature and title of the signature and th	Bir. N	W	29c. License	86860	97	Doc	signed (Month,	Day, Year) 7, 2010
045			30. Name and address of person Potrick Ben	n who completed cause of dealing 22 50	ath (Item 23a) (Ty	ne Street,	Baltimo	re, M	D, 2	1201	
Regi	State strar		31. Date filed <i>(Month, Day,</i> Yea <i>r)</i> UEC 1	4 2010 32. Registrar	's Signature	back					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 9, 2010 12:15P Physician/ Kathleen A. Loor Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Washington, 10/25/1933 1 □ M 2 🕅 F 77 579-42-3701 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Count Director 1 Yes 2 XNo Annapolis Anne Arundel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21401 Funeral 912 Perry Landing Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married Completed by White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) United Parcel Service Benefits Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ O'Donnell С. Catherine Clayton C. Lyles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 912 Perry Landing Court, Annapolis, MD 21401 Robert E. Loor/ Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a, Method of Disposition cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 12/14/2010 Crownsville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home Funeral Service License 21. Signatur 2973 Solomons Island Rd. Edgewater, MD 21037 hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. 23a. Pad 1. Enter the disease, or complication shock, or heart failure. List only one ca Immediate Cause (Final disease or condition resulting in death) Due to for as a consequence of) HYPERTENSION Sequentially list conditions. Examine riany, leaving to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live Birth
4 Pregnant a in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☑ Probably 4 ☐ Unknown 2 🗌 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Examiner physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ending p been signed by the atte should be detached for page 2 s eral Director: After this certificate filled in by the funeral director, pag hours after death.

Funera

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Physician,

Medical

Baltimore, Maryland 21215-0036

within 24 hours a Medical сотріете State

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2070482 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Keith Goulet, M.D. 600 Ridgely Avenue, Annapolis, MD 21401

31. Date filed (Month, Day, Year) **DEC 1 4**

Registrar

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State of Maryland	Department of Health	and Mental Hygien

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C Miles	/Medic Examin	_	. ,	10	e street end number)				4b. City, Town,	or Location of Dee	th 4c. County	of Deeth	
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	Funeral		5. Social Security 218-24-5	Number 6. S	ex 7. Age	(In yrs. last	M	Under 1 Yea onths Day:		Min. (Month, D	ay, Year)	Birthplace Country)	(State or Foreign
	Director	-	2-1-8-42-	575-3	BAM 2UF	80	Yrs.			5/15	/1930	MD	
	and and	1	Usual Residence	10b. County		10c. City, T	own or Locati	on				10d.	Inside City Limits
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	r 28s	9	10e. Street end No	umber				10f. Zip Code			10g. Citizen of V	Vhat Country?	
	h wit	a	216 N.	Commerc	ce Street			2161			USA		
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	To the Hospital or Attending Phys within 24 hours after death. To the Fureral Director: After this completaly filled in by the funeral director.	edical	29a. Certifier (Check only one)	2 Medical Exam	nysician: To the best of miner: On the basis of and manner stel	examination	edge, deeth on n end/or inves	tigation, in m	y opinion, death	plece, end due to the occurred et the time	e, date and place,	and due to th	e cause(s)
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene United State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vear Robert. Arthur McConnie 8:13 P.M.M Dec . Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Prince George's Clinton 9810 Campus Drive Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1XX M 2 □ F Oct 9, 1937 New York 73 **Director** 123 28 3889 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Tes 2XX No Maryland Prince George's Clinton 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral United States 9810 Campus Drive 20735 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 1954-1981 White Year or Dates. the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Service U.S. Postal Service Postal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H is marked ot Eleanor Saver Earl McConnie Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9810 Campus Drive, Clinton, MD 20735 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Shirley E. McConnie (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Arlington National Cemetery Jan 21, 2010 Donation 5 Other (Spegify) Arlington, Virginia 22. Name and Address of Facility Lee Funeral Hone, Inc. 6633 Old Alexandria Signature of Ferry Road, Clinton, MD 20735 23a, Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No 2 N Yes Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗷 Natural 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🚰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of pers n/who completed cause of death (Item 23a) (Type, Print) NBYH Oncalog

State

Maryland 21215-0036

Baltimore,

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Cole May 2010 4:50 Medical December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Meritus Medical Center Washington 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 1 🛛 M 2 🗆 F Davs Director 137-30-1993 72 Nov 1938 Ohio Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Washington Keedysville 靣 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20101 Marble Quarry Road 21756 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: "natural" Completed 3 ☐ Widowed 4 ☐ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing and Heating 0wner or other traumatic event, Be 17. Father's Name (First, Middle, Last) and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Eleanor Cole Richard George May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is Joanne K. May/ Wife 20101 Marble Quarry Road Keedysville, MD 21756 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 12/22/2010 Frederick, Maryland Stauffer Crematory 21. Signature of Juneral Service Licens 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA <u>7606 Old National Pike Boonsboro, MD</u> 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Imm diate Cause (Final Onset and Death Physician/ Obstruction with Reventer's ischemit disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Cardiom yopath Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 4 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner ath 28a. Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending Pl 24 hours after death.Funeral Director: After the 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accider
Suicide 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature **≰rl**d title of certifier , 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11116 Medical Campus Road an, AUDADA TRIQUE OH-10 31. Date filed (Month State Registrar

Box 68760

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene U 1 U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18 2010 Russell Francis Mizell, Jr. 17:52 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10926 Catholic Church Rd. Poo J Washington County 5. Social Security Number g. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Date or Day, **Funeral** 1 🗓 M 2 🗆 F Days Months Hours Min. 89 Sep. Director 219-36-4825 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington County Big Pool 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10926 Catholic Church Rd. 21711 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc ģ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Tree Farmer Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Francis Mizell, Sr. Blanche Weaner Mizell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Mizell-wife 10926 Catholic Church Rd. Big Pool, MD 21711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Smithsburg Crematory 12-20-2010 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ prostate of bue to (or as a consequence of): (metastatic disease or condition resulting in death) carcinoma 1eans Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ diabetes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? hypertension 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) ᇛ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifler 2gc. License number 29d. Date signed (Month, Day, Year) Contrea Kuttree Sand no D47451 December 20,2010 Cynthia Kuttner Sands no Hospice of Washington County 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-16 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Maryland 21215-0036

Baltimore.

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Mecamber 20,500 Elvnor Marie Matkins 7.21AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner washington n VIIIage 7. Age (In yrs. last birthday) Hagerstown Lutheran Lovenwood If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 89 191-16-0910 Director July 17,1921 Pennsylvania Usual Residence of Decedent 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director Maryland Washington Williamsport timore, Maryland 21215-0036 $\mathcal{U}\mathcal{L}\mathcal{L}$ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21795 USA or items 23a 7731 River Rock Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐Yes 2 No Specify: Specify: White 3 M Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Yanchulis Marcella ဂ Bolonis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Penny McDougal - Daughter 7731 River Rock Court Williamsport, MD 21795 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date t to permit. Pages Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 Removal from State 12-24-2010 5 Other (Specify) Indiantown Gap Nat. Cem. Annville, Pennsylvania 22. Name and Address of Facility 21. Signa kure of uneral Sery Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Syears /Medical Due to (or consequence of): Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has b autopsy perform 1 ☐Yes 24 ☐No 1 □ Yes 20 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. spital or Attendi nours after death. neral Director: A / filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D2836, auten 30. Name and address of person who completed cause of feath (Item 23a) (Type, Print) Shed- Heigston 1402176 Q5H-3 368 AWZAA. 5 HAR nul 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State DEC 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Raymond Donald McAFEE, SR. /Medical 4c. County of Death Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner If Under 1 Year 8. Date of Birth (Month, Day, Aug. 16, 9. Birthplace State or Foreign 5. Social Security Number **Funeral** Hours ^{Year)} 1930 Maryland 11 M 2 □ F 80 218-24-7722 Aug. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show or than "natural", or items 23a or 28a-f show Maryland Washington Hagerstown 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 U.S.A. 1059 Florida Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1951 1 Never Married 2 Married white 1 ☐Yes 2 🖾 No Specify: þ 1954 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10 optician is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental Raymond M. McAfee Ruth M. Athey Pages 1 and 2 should 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 933 Noland Drive, Hagerstown, Maryland Raymone D. McAfee, Jr. - son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State December Hagerstown Crematory Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Lic 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 14cow /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Year Month 5 Other (specify) ed by the a 9 Unknown 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? 1 □ Yes 2 No certificate To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕍 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-20-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X 14251 31. Date filed (Month 32. Régistrar's Signature State Registrar

DHMH 17 Rev 1/2001

1 - For State Registrar
1. Decedent's

Certificate of Death

1109	. 110.		
2. Date of Death			3. Time of Death
Month 2	Pay	2010	12:30 P

Physician /Medical Examiner

Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number,

6. Sex

4b. City, Town, or Location of Death

4c. County of Death Washington

Funeral Director

27 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Madical Examinar must be notified at Directo Funeral filed within 72 hours after þ Completed Be Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0036

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permit. Pages 1
Deportment of H
Important: if its
any injury or oti

Physician /Medical Examiner

signed by the ettending physicien and d be detached for use as the burial-transit

been si

director,

this After thi

death.

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within 24 hours after death To the Funerel Director: filled in by the Exam

Physician/Medical

Completed by

Be

မ

Certification:

Medical

The law requires that the death certificate be executed

Box 68760,

P.O. 1

Records,

Division of Vital Attending Physicien: Healthcare 4 agerstown f Under 1 Year If Under 24 Hrs. Days 1⊠M 2□F Months 86 Yrs.

8. Date of Birth (Month, Day Hours Aug.

9. Birthplace (State or Foreign Maryland

10a State 10b. County

Julia Manor

Social Security Number

220-28-7906

Usual Residence of Decedent

10c. City, Town or Location

10d. Inside City Limits

1924

Maryland Washington 10e. Street and Number

Hagerstown 10f. Zip Code

1 Yes 2 No

parts clerk

Yes 2 No 10g. Citizen of What Country?

white

233 Wakefield Road

11. Marital Status 1 Never Married 2 Married

21740 12. Was Decedent Ever in U.S. Armed Forces?

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

U.S.A. 14. Race - American Indian, Black, White, etc.

Specify.

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

1 ☐ Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Specify

16b. Kind of Business/Industry auto parts distributor

8 17. Father's Name (First, Middle, Last)

Charles Cecil McAllister

18. Mother's Name (First, Middle, Maiden Surname)

Blanch Trumpower

Minnich Funeral Home

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 233 Wakefield Road, Hagerstown, Maryland

Lorraine McAllister - wife 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place) Date December 23

22. Name and Address of Facility

20c. Location - City or Town, State

4 □ Donation 5 □ Other (Specify)

#Aagerstown Crematory

Hagerstown, Maryland

21. Signature of Funeral Service Licen

415 East Wilson Blvd., Hagerstown, Maryland 21740

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

resulting in death) Last

Coronary artilly	as
Due to (or as a consequence of): /	
Hyplerkalsin	cer)

Due to (o/a/ Consequence of):

Approximate Interval Between

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

Due to (or

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3. Probably 4 Unknown

24a. Was an autopsy performed? 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 \ Homicide

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

102

29d. Date signed (Month, Day, Year) 201

30. Name and address of person who completed eause of death (Item 23a) (Type, Print)

31. Date filed (Month,

6 Could not be determined

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink Fnsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 338 A M ecembe Mary Jane McClanathan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Pay, Year) Oct. 4, 1926 Funeral 9. Birthplace (State or Foreign Months Days Hours Min Director 215-20-9244 84 Maryland Usual Residence of Decedent 28a-f show 10a, State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number ö 10f. Zip Code 10a, Citizen of What Country? Examiner must be 23a Funeral 12112 Walnut Point Road 21740 USA items 2 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō ģ ☐ Never Married 2 ☐ Married Maryland 21215-0036 3 Widowed 4 □ Divorced 1 ☐ Yes 2 X No Specify. "natural", Specify: White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than r traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Det artment of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Elmer Guessford Jennie C. Hose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jacobs (Daughter) 13903 Fairview Road Clear Spring, Maryland 21722 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pauls Cemetery Dec. 20, 2010 Clear Spring, Maryland 21. Signative of Furnial 22. Name and Address of Facility Osborne Funeral Home P.A. Conococheague St. Williamsport, MD 21795 Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Heart Attac disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner oronary Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINER Physician: The law requires that the death certificate be executed the attending physician and hed for use as the bunal-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ MO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed' Yes 2 Mo 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 🖾 Yes 2 1 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Hospital or Attending Pl 124 hours after death.
 Funeral Director: After the Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural □ Accident
□ Suic 5 Pendina Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signled (Month), Day, Year) 30. Name and ad of person who completed cause of death (Item 23a) (Type 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Рм Physician 30 2010 lordan December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 🗆 M 2 🔀 F Days Hours Min MD 14 11 1996 216-47-5874 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b County 10c. City. Town or Location ms 23a or 28a-f show must be notified at 1X Yes 2 □ No Director Baltimore Baltimore MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 21224 Funeral 962 Elton Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No 11. Marital Status Black, White, etc. filed within 72 hours after 1X Never Married 2 ☐ Married 1 ☐ Yes 2X No altimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. High School Student 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be r and Mental F Pages 1 and 2 should be Katherine V. Wood Joseph H. McCann ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trau 962 Elton Avenue Baltimore, MD 21224 Joseph H. McCann/Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Tremation 3 Removal from State 12/16/2010 Alexandria, Va 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. permit. 21. Signature of Fugeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) HOUTE /Medical **Examiner** HCIDEMIA METHYLMALONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be exec physician an Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 🛣 No Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 X No has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 X Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 💢 Natural 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 RES-000 December 09 2010 - MD 30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 JUSTIN LOCKMAN WD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

16

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Mabel Martin Nov. 9:32 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Home Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) an. 4, 1916 Maryland 217-30-0406 94 Director Jan. Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 United States 3210 Norbeck Road 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Seconday (0-12) House Cleaner Residential and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Susie Hebron Eddie Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Valeria High, Sister 3210 Norbeck Rd. #238, Silver Spring, MD 20906 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 12/20/2010 Brentwood, Maryland Ft. M01102 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumoria Onset and Death Physician/ disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) e burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) detached g 🗌 Unknown P.0. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be c Completed by Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No page 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Division of Vital Other: 4 📉 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) Hospital: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D0062435 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Color of Rock VIIIe, MD 20850 31. Date filed (Month, Day, Year) State 16 Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 12, 2010 Year Carol Morelli 10:00 a Trene M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 3022 Aquarius Avenue Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Months 1 M 2 GF July 15, 1927 Hours 012-22-3239 83 Yrs. Massachusetts Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 ื No MD Silver Spring Montgomery 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20906 3022 Aquarius Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 ☐ Married ğ 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gemma Repetti Victor Morelli permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Robert McLaughlin/Nephew 24 North Stonemill Drive, Dedham, MA 02026 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. Date 1 XBurial 2 Cremation 3 N Removal from State cemetery, crematory or other place) Mount Benedict Cemetery 4 Donation 5 Other (Specify) 2011 West Roxbury, MA . Signature di Funeral Service Lice 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, o' con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List on the necessary are cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Alzheimer's Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Directo for as a consequence of and -transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

3 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Por in the past 12 months?

1 Yes 2 No
9 Unknown Day 9 Unknown P.0. ò s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an cate has I prior to completion of cause of death?

1 Yes 2 No autopsy performed? Hospital or Attending Physician: The Yes 21 N 25. Was case referred to medical examiner? Be Division of Vital 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) Hospital: 2 🔁 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending nours after death.

neral Director: A
filled in by the fi Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined thin 24 hours a the Funeral D Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Collen D33159 Dec. 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruth Kevess Cohen, MD 8700 Georgia Avenue, #400, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

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Michael Timothy McClyment

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State of Maryland / Department of He	ealth and Mental Hygiene	<u> </u>	9	7 1 1

Registrar Certificate of Death Reg. No.														
	Month Day Year										3. Time of Death 1843 hrs			
		4a. Facility Name (if not instituti 1813 Bloomingdale F	4b. City, Town, Queensto		4c. County of Death Queen Anne's									
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Y	ear If Unde	er 24Hrs.	8. Date of	Birth(MM/r	DD/YYYY)	9. Birth	place (State or	
Director		220-13-9854	1 X M 2 F	,			Months Days Hours			OCT. 7, 1972			Foreign MARYTAND	
any	İ	Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Local	tion							10d. Inside City Limits	
*	5	MARYLAND QUEEL	N ANNE'S		JEENSTO							- 1	1 Yes 2 No	
Maryl 28a-	Director	10e. Street and Number 10f. Zip Code								10g. Citiz	en of Wha	at Count	ry?	
n with the Maryland ms 23a or 28a-f sho be notified at once,	Ö	1813 BLOOMIN	IGDALE ROAI)		2165	8			UN	ITED	STA	TES	
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er dez	Yes 2 No												TTC	
urs afi tural'	b b	15. Decedent's Education (Spe	or Dates:		16a. Deceder	nt's Usual Occup		ind of wor	k done			of Business/Industry		
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5-0036 led within 7/ Hygiene. uther than	Completed	12			MECHA	NIC				A	AUTOMOTIVE			
15-00 filed wit Hygien d nther		17. Father's Name (First, Middle	•	•			18.Mother's			, Maiden S	Surname)		-	
21215-0036 und be filed within 7 Mental Hygiene. marked uther than c event, the Medica	To Be	HENRY C. MCCLY 19a. Informant's Name/Relations			10h Mailin	Addrona (Di-		OL BC						
	-	CAROL A. MCCLY		7R	4	Address (Street)								
Ore, MD ges I and 2 sh of Health an If item 27 i		20a. Method of Disposition		20b. P	lace of Dispos	ition (Name of c			ate		ocation - C			
Baltimore, permit. Pages 1 at Department of He Impurtant: If ite injury or other tr		1 X Burial 2 Cremation		om State CHE	ematory or oth	nerplace) ELD CEM	ETERY	DEC 201	.15	OF	ATMIN TO Y	7 7 777	E 160	
Baltimo permit. Page Department o Impurtant: injury or oth		4 Donation 5 Other S				-							E, MD	
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Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca	used the death. I	Do not enter th	ne mode of dying	g, such as ca	rdiac or re	spiratory a	rrest, shoc	k, or heart		Approximate Interval Between Onset and	
/Medical		Immediate Cause (Final disease	a. Intracerebel	llar Hemorrha	age								Death	
		or condition resulting in death)	Due to (or as a	consequence of)										
	Je	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of).	-						_	\dashv	· ·	
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18760, rifficate be ing physici as the buri	- Z I	IF FEMALE:	23c. If yes, outcome of pregnancy							23d.	Date of de	elivery		
8 E 60	ian	23b. Was decedent pregnant in the past 12 months?	1 Live bi	rth ant at time of deat	h -	al death 3	Ectopic	pregnancy		N	onth	Day	Day Year	
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Uni	nown 9 Unknow		tn 5 Oth	ner (Specify)								
P.O. Box 6ist that the death certained by the attendir		Part II. Other significant condit	ions contributing to	death but not res	ulting in the u	nderlying cause	given in Part	t I.	23e. Did	obacco us	e contribu	ite to the	cause of death?	
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tal Recions: The certificate ector, page	Be	25. Was case referred to medical		·		26.Plac	e of Death (C	heck only		ZNO		Yes	2 No	
Vit;	70 B	examiner? 1 ✓ Yes 2 No	Hospital: 1 In	patient 2 E	R/Outpatient	3 DOA	Other ₄	Nursing Ho	ome 5	Residenc	e 6 🗸	Other: S	cene	
After funera	آڃَ	27. Manner of Death 1 ✓ Natural 5 Pend	28a. Date o (Month, I	f Injury 2 Day,Year) 2	8b. Time of In		iry at Work?	- 1	d. Describe	how injury	occurred			
Pending Investigation Accident 2 Accident 3 Suicide 6 Could not be determined determined (Specific)														
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Hospit 4 hour 7 unera														
o the lithin 2 o the I	29a. Certifier 1 Check only 1 Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										ause(s)			
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O.C.M.E. December 9, 20									2010					
The same	ŀ	30. Name and address of person		,						1				
			ssistant Medical			Street, Balti	more, MD	21201						
St Regist	ate	31 Date filed (Month, Pay, Year)	2010 32/Reg	istrar's Signatule	par	1								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Day 7 Physician/ 2010 6:00A M Mable McCoy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Future Care Chesapeake Arno1d If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 940 Months sept 4 1 M 2 F Virginia 230-54-0941 Director 70 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or edical Examiner must be Funeral USA 1327 Harbor Rd. 21403 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Specify: Completed 3 - Widowed 4 - Divorced **Black** the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 11th 0 Cashier Gold Line Bus Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked o ည Edwin Jackson Josephine Ferguson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1422 East Cold Spring Lane Baltimore, Md. Lillie Megginson(Sister) Baltimore, 20b Milice of Osionin (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🗆 Removal from State Baptist Church 12-11-10 Concord, VA 4 ☐ Donation 5 ☐ Other (Specify) MMame Resease of AciliSons Mortuary, P.A. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 MOU 483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature nd title of cent 29d. Date signed (Month, D5311/ 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD EWATER COLONY 2007 ANAPOLIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Maryland 21215-0036

Box 68760

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 900 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Fairfield Nursing Home Crownsville Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year)}1922 1 🗆 M 2 🗷 Months Days Hours July 18 546-18-4607 88 **Director** California Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 💢 No Maryland| Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 800 Bestgate Road, #216 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 X Married 2 X No 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 3 years Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Michael Joseph Coyle Katherine Short Page 1 and 2 should and h 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Harold A. Molz/ Husband 800 Bestgate Road, #216, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 12/18/10 Annapolis, Maryland a legal dervice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Signal 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final and Reath Physician 10 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O, Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 1 Yes 2 4 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death?
1 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 100 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 1 Natural Accident Investigation within 24 hours after deatl To the Funeral Director. 6 Could not be ☐ Suicide ☐ Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) T 30 Name and address of p completed cause of de DEFENSE HWY ANNAPOL 31. Date filed (Month 32. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 📗 📗 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 December 1:22P Emily Jean Mosberger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 284 Cape St. John Road Anne Arundel Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** 1 🗆 M 2 👿 F 8/22/1929 Pennsylvania Director 162-24-9346 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours atter deam wou now many man Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland| Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 284 Cape St. John Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <u>\$</u> 1 Never Married 2 Married Yes 2 X No f Yes, Give 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Administrator Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen McClain Herbert Irving 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 284 Cape St. John Road, Annapolis, MD 21401 Nora J. Albrecht/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State Saxonburg Cemetery 12/16/2010 | SAXONBURG, PA. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home ale 2973 Solomons Island Rd. Edgewater, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ENGEN Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 1 N death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Passidence 6 Other (Specify) 2 1 No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 2 🗌 No Accident Investigation Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 29b. Signature and title of certifi 030718 30. Nang and address of p rson who completed cause of death (Item 23a) (Type, Print) John D. Jackson, M.D. 2003 Medical Parkway, Suite 100 Annapolis,MD 21401 31. Date filed (Month, OEC 1 5 2010 State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

	nd #1 per				Type or F									1 1 2 1 1		751													
AA (то неати:	Le	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.																										
	Physicia Medic		1. Decedent's Name	e (First, Middle, La thu	Barb	o McCullough						2. Date of Death Month 17 Day 13 Year 2010 3:15 P																	
	Examin Funeral Director		4a. Facility Name (if Bounds 18 Social Security No. 203–12–2	Health mber 6.8	Cent			y) If Under	30L	If Under	24 H <i>r</i> s. 8.	Date of Biri (Month, Da	I J	923 Pel	Geo	orges ate or Foreign vania													
	and show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location												10d. Insid	e City Limits														
	e Maryl 28a-f notified	Funeral Director	MD		George's	Bo	owie	1407.7	0-1-							Yes 2 No													
	with the 23a or	eral [10e. Street and Nun 3850 Enf	ield Cha:	se Ct.	#211		10f. Zip		0716			_	itize <i>n</i> of What C SA	ountry?														
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status	ied 2 🗆 Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	ent Ever in U. es? Mil No	S. 10	3. Was Deced If Yes, spec	dent of H cify Cuba	ispanic Orig In, Mexican		Yes or No- n, etc.)		14. Race - Ame Black, Whit Specify:															
5-0	"natul "natul	plete	(Spe	15. Decedent's E cify only highest gi			(Giv	cedent's Usua ve kind of wor	rk done d	ation during most	t of working		16b.	Kind of Business	Industry														
21215-0036	within 7 giene.	Specify: Spe									Own Hom	9																	
	e filed vital Hyged other event,	To Be	17. Father's Name (er's Name (Fir		Maider	Surname)															
Maryland	nould b nd Mer s mark umatic		JONN P 19a. Informant's Na	Barbor	ype, Print)		19b. Ma	ailing Address	(Street		ma Moc er or Rural Ro		r, City c	or Town, State, Zi	p Code)														
	nd 2 st ealth a m 27 is			. McCull	ough, Jr			62 Cot		d Ct.	, Fre	ederio																	
Baltimore,	. Page 1 ar ment of H tant: If iter jury or oth		4 Donation	☐ Cremation 3 ☐ 5 ☐ Other (Spec.	fy)	oto C	vete Vete	position (Nan rematory or o rans C	ther place lemet	ery		2010	Ch	ocation - City of eltenha		e													
Balt	permit Depart Impor any in		21. Signature of Fm	neral Service Licen	see			22. Name an							715														
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or local failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)										Approx Interval	imate Between and Death																	
	be executed sician and purial-transit	cal Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death) l	5	b. Due to (or C. Due to (or	as a conseq	,																						
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Or the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	ysician/Medi	ysician/Medi	ysician/Medi	ysician/Medi	ysician/Medi	ıysician/Medi	ıysician/Medi	ıysician/Medi	nysician/Med	nysician/Med	hysician/Mec	hysician/Mec	hysician/Med	IF FEMALE: 23b. Was decedent in the past 12 I 1 ☐ Yes 2 ☐ g ☐ Unknown	months? No	23c. If yes, outco	th 2 Tetaint at time of	al death 3	B		су				23d. Date of de Month	elivery Day	Year
ls, P.O.	uires that the des n signed by the a ld be detached i		Part II. Other signif	icant conditions	ontributing to dea	th but not res	sulting in th	e underlying o	cause giv	ven in Part I	l. 			use contribute to		/													
Records,	The law requires cate has been sig page 2 should b		Complete	Complete	Complete	Complete	Complete	Complete	Complete											24a. Was autoj perfo 1 Yes		death?	itopsy findir completion s 2 No	of cause of					
ital	sician: The certificate irector, pag	Be	25. Was case referrence examiner? 1 Yes 2	ed to medical	Hospital:				Oth	er:	th (Check onl)																		
of Vital	ng Physter this neral di	1 Inpatient 22 EH/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6																											
Division	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Certificate:	2 Accident 3 Suicide 4 Homicide	5 Pending Investigatio 6 Could not be determined	n 28e. Place of		ome, farm,	M street, factory	1 🗆	Yes 2 🗆	28f.	Location (S City or Tow		nd Number or Ru e)	ıral Route N	iumber,													
_	the Hospit. thin 24 hour the Funera mpleted fille	Medical	(Check 2 only one) 3	Certifying Phy Medical Exam Certifying Num	iner: On the basis	of examinatio	n and/or inv	estigation, in e, death occur	my opinion rred at th	on, death oc e time, date	curred at the	time, date a	and plac e cause	e, and due to the (s) and manner as	cause(s) and stated.														
0	o o o o o o o o o o o o o o o o o o o		29b. Signature and	G Certifier	M.D.			290) License	number DD6	:054	15	-	ate signed (Mont	-														
\odot	410		30. Name and addre	Ming	o Mil	/,	150		ea	142 0	Center	- Pr	,	Bowle	Mo	20716													
	Stat Registra		31. Date filed (Mont	DEC 15 2	010 32. By	istrar's Sig <i>n</i> a	ture	how	,																				

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			. For	State of Maryla	nd / Depa	artment of h	Health and	d Mental	Hygier	ne	
			1 - State Registrar		Ce	rtificate of	Death		Reg. I	40.2010	.1753
П	Physici	an	Decedent's Name (First, Middle, La.	,		1.6		2. Date Mont	of Death	Day Year	3. Time of Death
· Ald	/Media	cal	Helen.	Joanna 1	10100			De	C. 1.	1,2010	11:55 A M
	Examir	er	4a. Facility Name (If not institution, giv		مرماح	4b. City, Town, o			4	c. County of Death	2
-	Funeral		5. Social Security Number 6/S	ex 7. Age (In yrs	nter s. last birthday)	If Under 1 Year	or, dge If Under 24 H		of Birth th, Day, Yea	Dorche 9. Birth	place (State or Foreign intry)
	Director		217-30-8786	□M 2 1 75	Yrs.	Months Days	Hours Mi	in. \int_{A}^{Mon}			rginia
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation			/		10d. Inside City Limits
	Mary f sho	ţō	MD Davidh	actor	11	oridge					1 DeYes 2 □ No
3	h the	Director	10e. Street and Number	23 61	Cami	10f. Zip Code			10g. (Citizen of What Cou	ntry?
3	23a c	ral	1019 Ph:11:1	os Stree	+	214	5/3			215 A	
4	items	Funeral	11. Marital Status	12. Was Decedent Ever in l Armed Forces?	J.S. 13.	Was Decedent of H	Hispanic Origin? an, Mexican, Pu	(Specify Yes erto Rican, etc	or No-	14. Race - Ameri Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1		l□Yes 2121No	Specify:			Specify: 1:	
5-0036	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examination must be notified at		15. Decedent's Ed	fucation	16a. Dece	ient's Usual Occup	oation		16b.	Kind of Business/Ir	ndustry
21	ithin 7 ne.	Completed	(Specify only highest gra	College (1-4or 5+)	(Give life. I	kind of work done OO NOT use retired	during most of w d)	vorking		~ ~	1
2	filed within Hygiene. other than '		17. Father's Name (First, Middle, Last)		Proc	essing				Sea Foo	od
and		To Be	France (1 list, Middle, Last)			v	18. Mother's N		re.		
Mary	should be and Mental s marked o umatic ev	ř	19a. Informant's Name/Relationship (Nattord Type. Print)	19b. Mailir	g Address (Street	and Number or	Rural Route	SY ee	v or Town, State, Zi	n Code)
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Mary Enr	1a/5	1101	0 1			4 .	dae, MD,	
altimore,	ë ° = 5	1 1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, cren	sition (Name of natory or other place		Date		Legation - City or T	
<u>=</u>			4 ☐ Donation 5 ☐ Other (Specify) B _z	thel	Cemete		/18/1	0/00	Mbrid	ge, MD.
Ва	permit. Departs Imports any inj		21. Signature of Funeral Service Licen	see	22	Name and Addre	ss f Facility	Home	PA		MD. 21613
	_		23a. Paft1. Enter the disease, or comp	blications that caused the dea	th. Do not ent	10 Was	hing to	iac or respirat	CaM ory arrest	bridge	MD. Q1613 Approximate
_	Physician	S 1	Immediate Cause (Final	one cause on each line.	À	or the mode of dyn	19, 54511 45 5414	iao or respirat	ory arrest,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a conse	quence of):						6 years
	Examiner	_	Sequentially list conditions	b							
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Ent. Uncarlying Cause (Disease or injury	Due to (or as a conse	quence of):					3	
,	be executed ician and burial-transit	Exar	that initiated events resulting in death) Last	cDue to (or as a consec	quence of):						
3	icate be executed physician and s the burial-transit	ical		, d							
200	ertifice ling ph		IF FEMALE:								
POX	attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn	aldeath 3 □	Ectopic pregnance	у			23d. Date of deliv	ery Day Year
o j	y the	Completed by Physician/Med	1 □Yes 2 124No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5∟	Other (specify) _		-			24)
יי בי	s that ined b e deta	y Pt	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the un	derlying cause give	en in Part I.	23e.	Did tobacco	use contribute to t	he cause of death?
Vital Records,	equire en sig ould b	ed b	dementia,	diabetes,	hype	tensi	00,	.	1 ☐ Yes	2 No 3□ Pro	bably 4 ☐ Unknown
ည်	law re las be	plet							Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
	cate by page	Con						1 🗆 Y	performed?	death?	·
X	ung rnysician: The law requires that the death certific. After this certificate has been signed by the attending pl funeral director, page 2 should be detached for use as t	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of De				
5	g rnys er this eral di	۳: <u>۲</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time of	28c. Injur	4 Nursing			6 Other (Special	fy)
SION	ath. rr: Aftr re fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Work	ć? Yes 2 □ No`			ary socarroa	
2	ter de irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office		28f. Locati	ion (Street a	and Number or Rura	al Route Number,
ב ב	urs af urs af eral D		00-0-17	//							
3	24 ho 24 ho Fun etely	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the tin estigation, in my o	ne, date and pla pinion, death oc	ce, and due to curred at the t	o the cause time, date a	(s) and manner as : nd place, and due t	stated. o the cause(s)
4	To the rospital or Attending Prysician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the Leaders.	Me	29b. Signature and title of certifier	and the state of		29c. License	e nu m ber		29d. D	ate signed (Month,	Day, Year)
	n l		Popularo	n du		Hod	599-	73	/	2/14/10	
	(`)	Ī	30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type, F	rint)	0- 1	1 /	4	^	
	Char	· 0	31. Date filed (Month, Day, Year)	500 100 l.	oram b	le St.	Camb	ridge	MI	J	-
	Stat Registra		DEC 16 2010	ompleted cause of death (Itel	par	Les .					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ruth Wellington Mathias Physician/ December 11, 2010 Year 11:20 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min June 5, 1915 Director 557-01-5595 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified 1 ☐ Yes 2 🚟 o MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 10011 Summit Avenue 20895 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify: Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working marked other than marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Joseph Wellington Ina Rand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia Wilson/Daughter 14506 Perrywood Drive, Burtonsville, MD 20866 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🏝 Cremation 3 🗀 Removal from State Metropolitan Crematory Dec. 15, 4 Donation 5 Other (Specify) Alexandria, VA 2010 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 2010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Diarrhea Medical resulting in death) Due to (or as a consequence of): Examiner Acidosis Sequentially list conditions Physician/Medical Examiner Due to (or se a consequence or) cause. Enter Underlying Cause (Disease or iinjury that initiated events to immediate Acute Renal Failure attending physician and Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year the 9 Unknown 9 Unknown been signed by Ruth Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia of Vital Records, 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Mathias, 24a. Was an Jas autopsy performed After this certificate 1 Yes 2 No nours after death.

neral Director: After this certificated filled in by the funeral director, p. 🗌 Yes 2 😾 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 Ext No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ë 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury Certifica Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 20 address of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatgi, MD 8600 Old Georgetown Road, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date fled (Month, Day, Year)

December 11,

32. Registrar's Signature

Time of Death 1:00 Am 1_ For State Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER HENRIETTA FOGWELL MCNAMARA 18, 20 90 1:00 ам Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Larkin Chase Nursing & Restorative Bowie Prince Georges Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2**X** F 64 Months Days Hours Sept. 22 217-42-5451 Yrs 1946 Maryland Director Usual Residence of Decedent shov or 28a-f shov notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Kent Galena 1 Yes 2 X No 10e. Street and Number o 10f, Zip Code 10g. Citizen of What Country? 77 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 588 Mill Lane 21635 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Licensed Practical Nurse Hospital æ pe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Fogwell Lena Geary t. Page 1 and 2 should by rtment of Health and Mer rtant: If item 27 is marke njury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 588 Mill Lane Galena, MD. 21635 Robert Fogwell (brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ot Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Galena Cemetery 12/20/10 Galena, MD. 21. Sign of Filmeral Servic Licensee 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, solock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition EMENTIA Physician Medical resulting in death) Due to (or as a consequence of): Examiner ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence on attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENCEPHALOPATHY 1 Yes 2 No 3 Probably 4 Unknown BIPOLAR DISORDER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perforn certificate Yes 2 No 1 ☐ Yes 2 🗙 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes Other: 읻 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes Investigation
6 Could not be 2 🗆 No Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🕰 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) 22/10 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Adebowale Ajayi, M.D. 6201 Greenbelt Rd. Suite M-18 College Park, MD. 20740 31. Date filed (Month AN e) 4 2011 State egistrar's Signatu

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AMEND ITEM#19a, per1NF, 6913, 374/2011, ws

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 8:00 P M Doris Elaine Newsome Dec 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda Health & Renab Center Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🏻 F Days Hours Min. 9/15/1 Director 243-46-8944 80 Hertford Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "hatural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Hertford NC Ahoskie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1137 US Hwy. 13 South 2.7910 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) $\stackrel{\cdot}{12}$ College (1-4 or 5+) 5+ Teacher Public Schools I and 2 should be filed wit f Health and Mental Hygie item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vergie Deloatch Lee Flood Sr 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Jacqueline N. Williams 345 Rockville, Box MD20848 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Hillcrest Cemetery12/22/2010 Ahoskie, 22. Name and Address of Facility Reynolds Funeral Home 21. Signature of Funeral Service Licensee M0137 Ahoskie NC 27910 North Maple St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ CORONARY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 2 9 Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No page 2 To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 1 🗆 Yes 2 🕍 No Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 PNo Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Weertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Les ino 12/18/10 0005 7124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao 10110 Molecular Dr.#206 Rockville MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Der State of Maryland / Der State of Maryland / Der State of Maryland / Der Registrar	partment of Health and Notes me, 8920, 10/21/ Pertificate of Death	1ental Hygi 2011dhb Re	ene	1.757
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	023/2010 ^{Year}	3. Time of Death
-	/Media	al	Harrison M. Oglesby 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	<u> </u>	4c. County of Death	E3.CE PM
	Examin	er	Ft. Washington Hospital	Ft. Washington		Prince (enrae's
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day,		place (State or Foreign
	Director		248-58-5928 74 74	I manual pays manual manual	15/23/1	935	ZC
	dand ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		1	0d. Inside City Limits
	a-fsh	ctor	MD Charles Waldor	f			1 X Yes 2□No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
	eath w	Funeral	2L50 Philippians Pl. 11 Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp	ecify Ves or No-	USA 14. Race - Americ	can Indian
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003	ours a	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Bla	ack
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bu	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Nedeal Eventher must be notified at	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	laiden Surname)	
ylaı	Ment Ment arked atic e	To	Victor Oglesby	Annie w			
Mar	12sh thand 7 is m traum			ling Address <i>(Street and Number or Rui</i> Hunter St., Seneca			Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventinet must be notified at once.		C 2002		-	Oc. Location - City or To	own, State
mo	Pages nent o int: If i		Buriai 2 Cremation 3 C Hemoval from State		9/2010 11	est Minster	- SC
a <u>t</u> :	permit. Departm Importa any inju		TI TEGORITE	22. Name and Address of Facility St	rickland	Funeral Se	ervices
_	8 Q E # 9		23a. Part 1. Enter the disease, or complications that caused the death. Do not e	6500 Allentown Ro			Approximate
*****	law requires that the death certificate be executed Example 1 is a second of the attending physician and a second of the attending physician and a second of the attending physician and a second of the attending the attending the attending to the attending the attending to the	dical Examiner	shock, or heart failure. List only one cause on each line. Atherosomeographic cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	eratic disea	SE Hypo	thermia	Initerval Between Onset and Death
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.O. Box	at the death certific by the attending p tached for use as	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
S, G.	res that igned b	by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
ord	w require s been sign should b				1 🗆 Ye	s 2 No 3 Pro	bably 4 😿 Unknown
<u> </u>	The ate h	Completed			24a. Was an autopsy perform 1 Yes 2	prior to co death? No 1 □ Yes	ppsy findings available mpletion of cause of 2 ♀️No
Vital	yslcia iis certi directo	o Be	25. Was case referred to medical examiner? 1 □ A/res 2 □ Hospital: 1 □ Inpatient 2 □ FER/Outpatient 2 □ FE	Other:	h (Check only one	nce 6 □Other <i>(Speci</i>	6.1
Division of	g Pt fer th	on: To	27. Manner of Death	of 28c. Injury at	28d. Describe how		ject expose
Sio	tendi leath. tor: A the fu	catio	Accident investigation 12/06/2011 7:00	p M 1 ☐ Yes 2 🛣 No	temperatu	ure.	
_	F # F C	Certification:	4 ☐ Homicide determined determined determined determined determined Home determined	treet, factory, office		eet and Number or Run State) 2650 Ph	al Route Number, ilippians
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, det 2 Medical Examiner: On the basis of examination and/or and manner stated.		, and due to the ca		
	Vithi Vithi Com	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
	10) O M	0000 55697		12/7/10	
	St		30. Name and address of person who completed cause of death (Item 23a) (Type Tuan - Anh Vu, Mp	Print) 1711 Livingston R	d., Ft. V	Vashington,	MD 20744
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	~			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1035 PM MARY MARGUERITE PECK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin Chesapeake Hospice House Anne Arundel Harwood 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 👽 F Months Days Hours Min 219-12-3148 9/8/192 **Director** Usual Residence of Decedent ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 ื No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 989 Lanna Way 21401 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. 1 Yes 2 X No Specify. White 3 ▼ Widowed 4 □ Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) event, the 12th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ Henry Jerome Guy Sarah Ann Bowles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robert E. Peck, Jr./Son 2612 April Dawn Way, Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12/16/10 Edgewater, MD A Aurera Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Arrivon disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause F ter dearlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-t Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown ğ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 No ဂ္ 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 M Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of dug e Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760 Records, **Division of Vital** To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral

Baltimore, Maryland 21215-0036

Registrar

DHMH 17 Rev 7/2009

Medical

4 Homicide

29a. Certifier

(Check

determined

se of death (Item 23a) (Type, Print)

💢 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number

29d. Date signed (Month, Day, Year)

City or Town, State)

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Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. last b	birthday)	If Under 1 Yea			irth (MM/DD/YYYY) 9	Birthplace (State or Foreign Country)	
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215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	ral		dent Ever in U.S.	13. Was			Specify Yes or N		merican Indian, Black,	
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withi withi grene.	Completed	17. Father's Name (First, Middle, Last)		Techn	ICIAII	10 Mothodo No	one (First Middle	Maiden Surname)		
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MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatie event, the <u>Medica</u>	To B	19a. Informant's Name/Relationship (Type, Print) Si	ster l	19b. Mailing	Address (Stree			mber, City or Town, S		
WD 21 2 should I h and Mer 27 is man	_	Martha Cecilia Peralta-A	lgarin/				Harrison	, New York	10604	
		20a. Method of Disposition		e of Dispositi	on (Name of ce	metery,	Date	20c. Location - City	or Town, State	
MOF Pages ent of nt: If		1 Burial 2 X Cremation 3 Removal from 4 Donation 5 Other Specify:	d Edgewate	er, MD						
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		21. Si . ure of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Fune								
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Physician		23a. Part I. Enter the disease, or complications that cau failure. List only one cause on each line.	sed the death. Do	not enter the	mode of dying,	such as cardiad	or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and	
/Medical examiner		Immediate Cause (Final disease a. Asphyxia							Death	
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Sox 687 leath certific e attending I	sici	1 Yes 2 No 9 Unknown 9 Unknown	nt at time of death	5 Othe	(Specify)					
b.O.B that the de red by the detached f	Phy		eath but not result	ing in the un	derlying cause o	niven in Part I	23e. Did t	obacco use contribute	to the cause of death?	
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should t	Be	examiner? Hospital:	atient 2 🗸 ER/	Outpatient		Other Nurs		Residence 6 0	her	
1 of Vi ling Physi After this funeral dir	٦.	27. Manner of Death 28a Date of	Injury 28b	o. Time of Inju		ry at Work?		how injury occurred		
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Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	one) 2 Medical Examiner: On the basis of and manner state	examination and/or	r investigatio			d at the time, date			
	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed (
		unel 2			0.0.1	VI.E.		December 6, 2	2010	
11101		 Name and address of person who completed cause Ana Rubio MD. Assistant Medical Ex 			eet Raltima	ore, MD 2120			e-Bookid Po-	
ATO	ale	,	strar's Signature	-		JIG, IVID 2 121	J 1			
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 1, 2010 Physician/ 1:20 Рм Leonard Pirato Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Regency Park Gambrills If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F 11/4/1918 Country) W York 92 081-07-3900 Director Yrs. New Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified as any injury or other traumatic event, the Medical Examiner must be notified. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1X Yes 2 ☐ No Prince George's Bowie 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 20715 3505 Mase Lane USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1

Yes 2 □ No Black, White, etc. δ 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates unk White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Navigator U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam **Michael Pirato** unknown Gacinta Cirelli ည -unknown Pirato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3505 Mase Lane, Bowie, MD 20715 Leona June S. Pirato Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 12/15/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 20715 23a. 1. Enter in disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate rval Betweer Onset and Death Immediate Cause (Final Physician/ Phenny disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impry that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death signed by the a g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No Yes 2 2 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) the funeral director 2 1 No Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence this 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature number 29d. Date signer (Month, Day, Year) 13 10 200 Name, and address of person who completed cause of death (Item 23a) (Type, Print) llott MUdw

DHMH 17 Rev 7/2009

Registrar

Ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lois V. Pfleegor Physician/ 9:25 2010 A_M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel **Examiner** Heritage Harbour Health and Rehab If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 219–16–0497 8. Date of Birth **Funeral** Min (Month, Day, Year 1 M 2XXF 83 Director Maryland June Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Anne Arundel Annapolis 1 🗌 Yes 2 🔀 No 10e. Street and Number 10g. Citizen of What Country? U.S.A. 10f. Zip Code 1209 Green Holly Drive 21409 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No White 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed ANDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 7, Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) City of Annapolis Crossing Guard 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျ Virginia R. Linton Paul W. Waldrop 19a. Informant's Name/Relationship (Type, Print)
Nancy Connatser/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Green Holly Drive Annapolis, Maryland 21409 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 12/11/2010 Annapolis, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Cardiac Arrythmia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) by the attending physician and stached for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 XXIVo g ☐ Unknown q | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Failure to Thrive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎎 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed? 1 Yes 2 No Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 XXX Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 XX Jursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practions. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D57028 December 7, 2010 and address of person who completed cause of death (Item 23a) (Type, Print)
tya Chopra 600 Ridgely Avenue, Suite 231 Annapolis, Maryland Aditya Chopra 31. Date filed (Month, Day Year) DEC 08 2010 Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 29d per med cert G911 1/19/11 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 Physician/ Month PAYNE ADOLPH 2010 JR. DECEMBER 9:44 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE"S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, APRIL 28 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 1 M 2 - F 56 577-74-0221 Yrs. WASHINGTON, DC **Director** 1954 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 √2 Yes 2 □ No PRINCE GEORGE'S HYATTSVILLE MD 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country ms 23a or must be i Funeral 3988 WARNER AVENUE #D5 20785 USA "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Il Hygiene. 12TH COOK FEDERAL GOVERNMENT 1 and 2 should be filed wit of Health and Mental Hygie item 27 is marked other other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ EULA FLEMING ADOLPH H. PAYNE SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3988 WARNER AVENUE D5 HYATTSVILLE, MARYLAND 20785 BARBARA PAYNE/WIFE other t permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other it 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State □yBurial 2 □ Cremation 3 □ Removal from State 12/11/2010 LANDOVER, MARYLAND HARMONY CEMETERY 4 Donation 5 Other (Specify) J.B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ LATA L disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions Examiner Dire to (or its a nonsequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year the g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 🔀 No 2. No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 2 WNo Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 No Investigation

Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature nd title of c 29d. Date signed (Month, Day, Year) D63688 2008 12/14/10

Registrar
DHMH 17 Rev 7/2009

State

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3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

GRIFFIN DAVIS M.D.

31. Date filed (Month, Day, Year)

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		For State Registrar			,	•	rtificate of I				Reg. N	21111		50
Physicia Medic		1. Decedent's Nam		ast) ETERSON						2. Date of De Month December		ay 201(3. Time of De 6:35	
Examin	er	1303	OLD MU	ve street and number) SKET LANE		4b. City, Town, or Location of Death FORT WASHINGTON					4c. County of Dea			
Funeral Director		5. Social Security N	4876	Sex 1 X 2 F 51	e (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da OCT • 3		9. Bli WAS	thplace (State or F United) HINGTON,	
aryland a-f show ied at	ctor	Usual Residence of 10a. State MD	10b. County	Coorsela	10c. City,								10d. Inside City	
ith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Nur 1303 01d	mber	George's	r	ort	Washingto 10f. Zip Code	on 20744			10g. C	itizen of What C		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	≦	11. Marital Status	ried 2 🛚 Married	12. Was Decedent E		nes	Was Decedent of H If Yes, specify Cuba 1 Yes 2 XNc	lispanic Ori an, Mexicar		cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit		
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mit. Page 1 ar bartment of He portant: If iter injury or oth		20a. Method of Disp 1 Burial 2 4 Donation 21. Signature of Fu	Cremation 3 5 Control Other (Spe		cen	netery, crer ERDAL	osition (Name of matory or other place of CREMAT) 2. Name and Addre	ORY	12/13	Date 3/2010 B. JEN	RIV		MARYLAND	
perr Dep any any		23a, Part 1. Enter t	the disease, or co	mplications that caused one cause on each line		7	474 LAND	OVER :	ROAD	HYATTS	VIL	LE,MARYI	AND 2078 Approximate Interval Between	5 en
Physician/ Medical Examiner		Immediate Cause (disease or condition resulting in death)	on (Due to (or as a	a consequen		<i>Jultiforn</i>	ne					Onset and Dea	ath
0 m =	cal Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death) in	rlying iinjury s	c. Due to (or as a										
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	<u> </u>	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal d	leath 3	Ectopic pregnand	су				23d. Date of de Month	livery Day Yea	ır
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the Hospi nin 24 hou the Funer	Medical	(Check 2	Medicai Exa	nysician: To the best of miner: On the basis of ex urse Practioner: To the	xamination ar	nd/or invest	tigation, in my opinie	on, death or	ccurred at	the time, date a	and place	e, and due to the	cause(s) and manne	er stated
P With D		29b. Signature and	title of certifier		2.		29c. License	e number	667	13a	29d. Da	ate signed (Mont. $\frac{1}{200}$	n, Day, Year)	
T		ALDON C	HIU M.D.	completed cause of de 6900 GEORG				HINGT	ON,	DC 2001	1			
State Registra	-	OEC 1 3 2		32. Registra	ar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2010 DEC JASON DARREN PETO 5:47 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🔀 M 2 🗆 I Days (Month, Day, Ye JAN 28 571-97-6351 Director 31 CALIFORNI Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No WA CLARK VANCOUVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9300 NE 222nd AVE 98682-9786 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates. 2004-2010 WHITE permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 UNITED STATES MARINE CORPS DEFENSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ERNEST PETO JANIE WESSELMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANIE PETO/MOTHER 9300 NE 222nd AVE VANCOUVER WA 98682 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEM. 12-18-2010 RIVERSIDE NAT'L. RIVERSIDE, CA. Signature of Funeral Service Ligensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) BLAST INJURIES Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Stransit . that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 🗆 No 1 Yes 2 X No Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 x Yes 2 ☐ No Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔲 Natural 5 Pending NOV 24 2010 12:15 PM 1 X Yes ☐ Accident ☐ Suicide Investigation Could not be STEPPED ON IED Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 X Homicide determined City or Town, State)

Box 68760 P.O. To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, of Vital Division

9+1

Medical

29a. Certifier

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

DEC

ELIZABETH

ROUSE

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LtCo1 MC

29d. Date signed (Month, Day, Year) DIC 08 2010 0101054497 (VA)

SANGIN PROVENCE

ARMED FORCES INSTITUTE OF PATHOLOGY

1413 RESEARCH BLVD. ROCKVILLE MD 20850 USAF Registrar's Signature

BATTLEFIELD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 13. Physician/ Beverly Jean Pine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Washington Hagerstown Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** (Month, Day, Year) 4-25-1947 Country)
MD 219-52-1647 1 ☐ M 2 🛣 F 63 Director Usual Residence of Decedent a 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Clear Spring 1 🗌 Yes 2 🔀 No 10f. Zip Code 21722 10g, Citizen of What Country? 10e. Street and Number U.S.A. Funeral 12114 Hanging Rock Road . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. White Yes 2 X No ò 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry residence Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred R. Lettich Glen M. Craiq ည 19a. Informant's Name/Relationship (Type, Print) spouse Lloyd P. Pine, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lloyd P. Pine, 12114 Hanging Rock Rd. Clear Spring, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a, Method of Disposition 12-9at6cemetery, crematory or other place)
BlairsValley Cem. ⊠ Burial 2 □ Cremation 3 □ Removal from State permit. Page 1 Department of Important: If it any injury or o Clear Spring, MD 2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 21. Signature of Funeral Service Line se 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ardiony Physician/ disease or condition Medical resulting in death) Due to (or as a consequence f) Examiner tensica Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events at initiated events.) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as. IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Pregnant at time of death has been signed by the signed by the signed by the signed be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed Myperlipidemia 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy has page 25 Was case referred to medical 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 1 Yes 1 Inpatient 은 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: atural 5 Pending Accident Investigation ☐ Accider 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number and title of certifier 12/13/2010 100 38968 24 N. Walnut St 3H-5 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d per hosp. G911 1/28/11 dk. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 A I A 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 14 Physician/ 2010 John J. Powers 1412 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Har ford Havre de Grace Harford Memorial Hospital 5. Social Security Number 8. Date of Birth Jan . 27, 1948 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 214-52-3521 1 **∑** M 2 □ F 62 Washington, DC Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 28a-f Maryland Cecil Port Deposit 1 X Yes 2 No b 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21904 74 North Main Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. 1 967-70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Specify. "natural" 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit Page 1 and 2 should be filed within 72 Depar ment of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the unkňown unknown unknown unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Olivet Jack Powers 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 1400 South Charles Street, Baltimore, MD 21230 19a. Informant's Name/Relationship (Type, Print) Bryan A. Bishop, Esq. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State ò Crownsville Cemetery 12/27/10 |Crownsville, Maryland injury 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Name and Address of Facility ee A. Patterson & Son Funeral Home, P Perryville, Marvland 21903-0766 Thomas Mit 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 No Minknown certificate has been si lirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🔀 No 25. Was case referred to medical you Powers Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ื No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🕰 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🖄 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0069 12/14/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WON AVE WITH AWALA 31. Date filed (Month, Day, Year) **DEC 2 0 2010** 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

771674

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Edmond Gregory Psaltis 2010 02:25A M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Bethesda Suburban Hospital Montgomery 8. Date of Birth (Month, Day, May 22 9. Birthplace (State or Foreign Country)
Washington, D.C 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 F Hours Min. Year Months Director 579-36-5089 81 1929 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Md. Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3524 Fitzhugh Lane 20906 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Korean Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 8 Law Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Gregory Psaltis Helen Keart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret M. Psaltis / Wife 3524 Fitzhugh Lane, Silver Spring, Md. permit. Page 1 and 2 Department of Healtl Important: If item 2: any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 12/15/10 Silver Spring, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville Losto m-00470 20882 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical Intracranial Hemorrhage disease or condition resulting in death) Examiner mr Coagulopathic secondary to Warfarin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). 192 sician and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires to hours after death. Funeral Director: After this certificate has been sign Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 1 Yes 2 No **Division of Vital** filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. injury at 28d. Describe how injury occurred work? 1 ☐ Yes ☐ Natural Accident 5 Pending PUSITION FELL FROM STANDINL Investigation 0100AM 12-11-10 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 3524 FITZHULH LAND SILVER SPRING mb 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) OffuA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Babak Pirouz, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Chillen

8600 Old Georgetown Road, Bethesda, Md.

arks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dec. 11 Year Physician/ M George Wesley Roe 2010 3:09 P Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year) Oct 4. 1945 If Under 1 Year I If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours Oklahoma 577 60 9006 Director 65 Oct 4. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f show 10a. State 10b. County Director r 28a-f s notified 1 Yes 2XX No Maryland Prince George Temple Hills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ian "natural", or items 23a on Medical Examiner must be Funeral 4311 23rd Pkwy Apt 611 20748 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) the Security Officer Smithsonian Institute Ith and Mental Hygier 27 is marked other transactions. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If Item 27 is marked of any Injury or other traumatic eve George Booker Roe Florene Grayson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janith Roe (Wife) 4311 23rd Pkwy Apt 611, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State Lee Crematory Dec 14, 2010 Clinton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Lice MO1555 Ferry Road, Clinton, MD 20735 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coroner disease or condition Due to (or as a conse vience of): Medical resulting in death) Examiner MYOCA Se uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or ilnjury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Bradycar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27500 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 1 Tes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Wertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier H0061922

Registrar
DHMH 17 Rev 7/2009

State

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Registrar's Signature

ucun

Somoths Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year)

6

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William G. Robertson 10, 2010 1:04 P M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 72 Yrs 8. Date of Birth (Month, Day, Year) Sept. 18,1938 Social Security Number **Funeral** Months 1 XM 2 □ F Director 219-34-2542 ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State filed within 72 hours after death with the Maryland Director Anne Arundel Arnold MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21012 1236 Taylor Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Completed by White Baltimore, Maryland 21215-0036 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Owner/ Operator HVAC Company 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item Z7 is marked of any injury or other traumatic ever any injury or other traumatic evence. ည Mary E. Federline William T. Robertson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1236 Taylor Avenue Arnold, MD 21012 Joy Faye Robertson / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of December Lakenont Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State Davidsonville, MD 2010 4 ☐ Donation 5 ☐ Other (Specify) P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 Signature of Finera 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and D th Immediate Cause (Final Preumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Shock 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an acute autopsy performed? ortery Coronory this certificate 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) Hospital or Attending 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year)

State Registrar

15,

MID

ne and address of person who completed cause of death (Item 23a) (Type, Print)

terson

Registrar's Signature

12-10-2016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 3:26PM Lloyd т. Roberts Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Doctors Community Hospital Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. April Da 1 Year 935 Months Director 579-78-3326 75 Yrs. Trinidad Usual Residence of Decedent shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified 1 ☐ Yes 2 🔀 No Maryland | Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be Funeral 4200 Lavender Terrace 20720 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, ortant: If item 27 is marked other than "natural", or itel injury or other traumatic event, the Medical Examiner Armed Forces? Black, White, etc þ 1 X Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Maryland 21215-003 Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Mechanic Self Employed should be filed we and Mental Hyg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Roberts Lena Taylor permit. Page 1 and 2 should be Department of Health and Meni Important; if item 27 is marke any injury or other traumatic one. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 4200 Lavender Terrace Bowie, MD 20720 Heather Roberts (Niece) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 18,2010 Freeport, Trinidad Anglican Public Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Sict only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician/ ARDIOP ULMONARY FAILURE disease or condition Medical resulting in death) Examiner PULMONARY DISEASE OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CONGESTIVE HEART 1 Yes 2 No 3 Probably 4 Unknown PNEUMONIA PIRATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RENAL FAILURE 1 Yes 2 No 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tyes 2 🔄 No Other: ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending in 24 hours area. The Funeral Director: Afternated filled in by the funeral filled in by the fun 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 12-10-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN EXTON, MD & SUS GOOD NO huckld., Carham, MD. 20706 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **DEC 1** 3 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14 2010 Month Margaret Lee RUTH December 17:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15542 Broadfording Road Clear Spring Washington 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Y June 29 **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Days **Director** 218-24-1517 82 Maryland Jun<u>e</u> Usual Residence of Decedent show 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Washington Clear Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 15542 Broadfording Road 21722 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Manager Theater Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stewart Slifer permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic Irene Hazel Amsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis J. Ruth - Husband 15542 Broadfording Road, Clear Spring, Md. 21722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 12/16/10 Hagerstown, Maryland 21. Signature of Funeral Service Licensi 22. Name and Address of Facility Minnich Funeral Home Holid 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to introduce cause. Enter Underlying Examine Daw to for es 5 purisuagino Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2-9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Strile 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No Yes 2 VNo 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 5 Pending 2 Accident
3 Suicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 1-0056413 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USH-5 SAN JA OPAI CT. WAGERSTOWN SAXEN 1138 egistrar's Signatu Registrar

Box 68760

P.O.

Records,

Division of Vital

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 4772

Christopher	Robir		osencrans, Sr. St 1-For State Registrar	tate of Maryl		epartme C <i>ertifica</i>			nd Men	tal Hy	_	eg. No.			
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			4a. Facility Name (if not institution 1624 Midland Road	on, give street and n	umber)		41	. City, Town, o Edgewater				4c. County of Death Anne Arundel			
Fune Direc			5. Social Security Number 6. Sex 7. Age (In yrs. last by $214-82-0685$ $1 \times 10^{-1} \times 10^{-1}$ 1×10^{-1}			nday) If Under 1 Year If Under Months Days Hours				— ` 1_		Fore			
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15-0036 Hilled within 72 hours after death with the Maryland Hygiene. On the Maryland and the than "natural?" or items 23a or 28a-f sho	miner must be	⋧┞	1 Never Married 2 M 3 Widowed 4 X Div 15. Decedent's Education (Spe	Armed F 1 Yes Vorced If Yes, Give Yes	orces? 2 X N	Мо	If Yes	, specify Cuba	an, Mexican, lo s <i>pecify:</i>	Puerto R	ican, etc.)		White, etc. Specify: Wh	ite	
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Baltimore, permit. Pages I ar Department of Hee Important: If ite	ury or othe	١	1 Burial 2 Y Cremation 4 Donation 5 Other Sp 21. Signature of Funeral Service	pecify:		cremator Kalas	Crem	atory			8/2010 ge P. 1		_	, Maryland	
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/Medic			failure. List only one cause Immediate Cause (Final disease or condition resulting in death)				Card	iovascu	ılar D	iseas	se			8etween Onset and Death	
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the 1st after cleath.	rector, page 2 should be				_			<u></u>		_	24a. Was a autops perform	sy med?	prior to death?	atopsy findings available completion of cause of the second secon	
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Of Ving Physi	funeral di	· 🛌	1 ✓ Yes 2 No 7. Manner of Death	28a. Date			ne of Inju		ıry at Work?	Nursing H	d. Describe h		occurred	: Scene	
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Div e Hospital o 124 hours af e Funeral D			4 Homicide determined the determined the determined determined the determined determined the determined determined the determined de	yslcian: To the bes								e(s) and			
To the within 2 To the I	Medical	2	9b. Signature and title of certifier	niner: On the basis of and manner st	of examinatio ated.	n and/or inve	estigation	in my opinion 29c. Licens		urred at th	e time, date a		e, and due to the ate signed (Mor		
		3	0. Name and address of person v	who completed caus	e of death (It	tem 23a)		O.C.	M.E.			Dece	ember 21, 20	010	
	State		Donna M. Vincenti, MD	Assistant M		aminer	111 P	enn Street,	, Baltimor	e, MD 2	21201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician/ Summers Lorraine 3:53 PM Janet Jecember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fahrney-Keedy Home & Village Washington Boonsboro 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🛣 F Hours Director 85 216-22-8179 AprilUsual Residence of Decedent fshow 10b. County 10c. City, Town or Location 10d. Inside City Limits : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Tes 2 No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21713 U.S.A. 8507 Mapleville Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. nd Mental Hygiene. marked other than "natural", 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Board of Education Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Keadle Blanche Naomi Jones Russell Ellsworth of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard E. Summers/Husband Blue Ridge Drive Boonsboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Boonsboro Cemetery 12/26/2010 Boonsboro, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, Signature of Fund 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1 Enter the disease, or compleshoot, or heart failure. List only one Immediate Cause (Final at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Cardiovascular Dispuse Onset and Death Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed that initiated events To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 28d. Describe how injury occurred Certificate: Natural Accident 5 🔲 Pending work? 1 ☐ Yes 2 ☐ No Investigation within 24 hours after deat To the Funeral Director: Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number -2010 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 03H-6 1126 Opal Court Hagerstown, Maryland 21740 MDMuhammad Waseem, 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 10 For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edna Beatrice STICKLER December 77, 2010 3:15pmm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Boonsboro Fahrney-Keedy Home Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-82-6392 Days Dec. 3, Year 1913 1 M 2 to F 97 Maryland **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Metal Hygiene.

Important: I firem 27 is marked of ther than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Washington Boonsboro Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21713 U.S.A. 8507 Mapleville Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) her own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bessie May Hitzelberger Alvey Gardner Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18078 Lincoln Road, Percellville, Virginia 20132 Susan Yantis - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 15 January Rose Hill Cemetery 4 Donation 5 Other (Specify) Clear Spring, Maryland 2011 21. Signature of Funeral Service Ligense 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Wroses 5. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consulence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit onsestive that initiated events resulting in death) Last Due to for as a consequence of) Be Completed by Physician/Medical Ovarian Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months?
1 Yes 2 No 3 L Ectopic pregnancy Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? performed Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 힏 2 10 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0050362 in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-1 Dr. Vincent Cantone, 13424 Pennsylvania Avenue Suite 205, Hagerstown, Maryland 21742 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <u>0</u>9^{Day} Physician/ Month 2010 0730 Alonzo Smith, Jr 12 Ernest Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1 1 AM 2 A Days Hours Min Country) DC Director 578-70-5997 58 Usual Residence of Decedent Show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Prince George's Bladensburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3801 Kenilworth Ave. 20710 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 24 No
If Yes, Give Black, White, etc. Completed by 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 3 years Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ernest A. Smith, Sr. Velma E. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #4 Mount Rainier, MD 20712 Velma E. Thomas/Mother 2708 Webster St. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/18/2010 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 22. Name and Address of Facility Marshall-March Funeral Home Tune of Funeral Service Lice NW Washington, DC 20011 9th St. 4217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Dav Month Year Pregnant at time of death Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy perform 1 ☐ Yes 2X No Yes completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🕽 No Other 욘 1 ₺ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of De th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and only one) 29b. Signature 29d. Date stoned (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

Dr.

Cheverly,

3001 Hospital

32. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Catevenis,

16

(Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:30p M 2010 Schwartz Osler <u>December</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Collingswood Nursing Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗶 M 2 🗆 F Months Hours 02/13/1924 Washington, DC 86 721-12-7262 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 299 Hurley Avenue 20850 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ 1 X Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Caucasian 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Electronic Repairman Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Osias Schwartz Anna Reifler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wendy Anderson - Durable POA 3516 Hamlet Place. Chevy Chase. Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 12/14/2010 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Crem. Ctr 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Failure to Thrive Sequentially list conditions. if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the and be detached for 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 2 🗓 No 3 🗌 Probably 4 🗆 Unknown Completed certificate has been irector, page 2 shoult 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: X Natural 5 Pending Accident Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 2010 D0062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 10110 Molecular Drive, Rockville, Maryland 20850 Sayed Elsayyad, 31. Date filed (Month, Day, Year) State 16 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 15, 2010 Belle **SCHECHTER** 9:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bedford Court Rehab. Center Silver Spring Montgomery 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours July 3ay, 1924 1 □ M 2 🗓 F New York **Director** 085-18-2350 86 Usual Residence of Decedent should be filed within 72 hours and and Mental Hygiene.
I so marked other than "natural", or items 23a or 28a-f show it marked other than "hatural", an items 25a or 28a-f show arice event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Tes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3701 International Drive #538 20906 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. <u>۾</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ¥ No Specify: Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary U.S. Government errit. Page 1 and 2 should be flied wit be artment of Health and Mental Hygiei hyportant: If item 27 is marked other in ny injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frances Schmertz Samuel Dicker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 928 Cresenwood Road, E. Lansing, MI Michael G. Schechter, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Lebanon Cemetery 12/17/10 Adelphi, MD . Signature of Fundral Sep MOIOOS TO ACT THIS KYS HET YEW Funeral Home 254 Carroll St., NW, Washington, 23a. Part 5 fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atrial Fibrillation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner <u>Hypertension</u> Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-1 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 XNo 3 Ectopic pregnancy
5 Other (specify) Month Day Pregnant at time of death Year 1 ☐ Yes 2 L 9 ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary Embolism 1 ☐ Yes 2 🂢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has page 2 s performed? Yes 2 X N Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2**X** No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20 D0067092 12/16/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weihan Wang, M.D. 15245 Shady Grove Rd-Suite 130; Rockville, MD 20850 31. Date filed (Month, Day, Year) 32, Registrar's Signature State UEC 16 2010 Registrar

Box 68760

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Records,

Division of Vital

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Registrar

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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Marr 3 🏿 Widowed	ried 2 Married 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.	No		Yes, specify Cuba			can, etc.)		Black, W	hite, et	
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Division of Vital Records,	Jing F J. After 1 funers	Certificate:	27. Manner of Death 1 🔀 Natural	5 Pending	28a. Date of injui (Month, Day		28b. Time of injury	28c. Injury work	at Yes 2		d. Describe h	now inju	ury occurred		
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Physici	an/	1. Decedent's Name (First, Middle	e,Last)						2	Date of Deat		V	3. Time of Death
Medical Exam	iner	Charles Nicho	olas Schoo	enfel	d					Month December	Day 10, 2010	Year)	1850 hrs
		4a. Facility Name (if not institution				4	b. City, Town, o	or Location	n of Death		4c. Cou	inty of De	eath
		6812 Schaadts Road					Middle Riv	er			Baltii	more C	ounty
Funeral	•	5. Social Security Number	6. Sex	7. Age (Ir	yrs. last birt	hday)	If Under 1 Ye	ar If Un	der 24Hrs.	8. Date of Birt	h (MM/DD/Y	YYYY 9.	Birthplace (State or
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-7 abs		20a. Method of Disposition	reid - Mi	<u> </u>					-	Date			
s 1 as f He If ite		1 Burial 2 X Cremation	3 Removal fr	om State	cremate	ory or othe	ion (Name of co er place)		ľ			-	or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur injury or other traumatic event, the Medical Exam		4 Donation 5 Other Sp		o, o.a.to	Baltin	nore	Cremato	ry	12/	13/2010	Ba1	timo	re, MD
nit. artm		21. Signature of Funeral Service	Licensee	i		22. Na	me and Addres	ss of Faci	ity Ioh	р М. Та	vlor	Funo	ral Home
E P P P		Miglin T. Klober	1			14	7 Duke	of G	louces	ster St	. Ann	ano1	is, MD 21401
Physician		23a. Part I. Enter the disease, or		aused the	death. Do no								Approximate Interval
/Medical		failure. List only one cause											Between Onset and Death
xaminer	- 1	Immediate Cause (Final disease or condition resulting in death)	a. Cirrhosis of Due to (or as a										Dodai
			Due to (or as a	conseque	ence or).								
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a	conseque	ence of):								13
	Examiner	cause. Enter Underlying Cause	C.										
	E I	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):								10
ecuted and transi			_ d										
exerian a	n/Medical	UNPENDED	AMENDED										
8760, ifficate be ex ng physician is the burial	Aec	IF FEMALE:	23c. If yes,	outcome o	f pregnancy						23d Dat	e of deliv	rerv
1987 Triffica Triffic	2	23b. Was decedent pregnant in the past 12 months?				Feta	al death 3	Ectop	oic pregnanc	;y	Mon		Day Year
Sox 687 leath certific e attending p for use as th	<u>:</u>			ant at time			er (Specify)						
Box 68 e death certi the attendin ed for use a	Physicia	1 Yes 2 No 9 Unk	nown 9 Unkno	own									
at the		Part II. Other significant conditi	ons contributing to	death but	t not resulting	j in the un	derlying cause	given in f	Part I.	23e. Did tot	oacco use c	ontribute	to the cause of death?
P.O. res that the signed by be detac	ğ									1 Yes	2 🗸 No	3 P	robably 4 Unknown
ds equip	Completed		· -							24a. Was a	n 2		autopsy findings available
law r	힐									autops		prior t death	o completion of cause of ?
Re The cate	팃									1 ✓ Yes 2		1 🗸	Yes 2 No
Em:	Be	25. Was case referred to medical examiner?					26.Plac		n (Check onl	ly one)			
Division of Vital Records, lat or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be a by the funeral director.	P	1 ✓ Yes 2 No	Hospital: 1 I	Inpatient	2 ER/0	utpatient	3 DOA	Other ₄	Nursing I	Home 5 🔲 F	Residence	6 🗸 Otl	her: Scene
Of Pig Pi		27. Manner of Death	28a. Date	of Injury , Day,Year)	28b. 7	Time of Inj	ury 28c. Inj	ury at Wo	rk? 28	3d. Describe h	ow injury oc	curred	
ath.	흵	1 Natural 5 Pendi	ing	,, , ,,			1	Yes 2	No				
r Att	낊		tigation 28e. Plac	e of Injury	- At home, fa	rm, street,	, factory, office	building,	etc. 28	3f. Location (S	treet and Nu	umber or	Rural Route Number, City
Division ospital or Attendable hours after death meral Director:	Certification:		not be (Specify)							or Town, St	ate)		
Division of Vital Records, P.O. Box 68760, the Hopital or Attending Physician: The law requires that the death certificate be executed nin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and phielely filled in by the funeral director, page 2 should be detached for use as the burial - transitions and transitions and the funeral director.		29a. Certifier	ysician: To the bes	et of mulic	auledaa daa	ith occurre	ad at the time	tate and -	lace and di	ie to the course	(e) and m	nner so s	tated
the H thin 24 the F	Medical	(Check only	nysician: To the bes niner:On the basis o										
To the within To the comple	9	29b. Signature and title of certifier	and manner s				29c. Licen						Month, Day, Year)
		orange and title or certifier	n it.				- 1		,				
		Mouhante	The Va	ul			0.0	M.E.			Decemb	per 11,	2010
11 12	- 1	30. Name and address of person	who completed caus	se of death			111-						
升 1() 1	- 1	Margarita Korell MD.	Assistant Med	dical Exa	aminer	111 Pe	nn Street, E	Baltimor	e, MD 21	201			
St	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's S	ignature /	1							
	rar	UEU 1 4	2010	eneur	1 4.	Da	Kel						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ϊ3, 20T0 December 8:16A Donald Lee Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Somerford Place Annapolis . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Days Hours Min. 5/4/1927 Washington. 218-24-0017 83 **Director** Usual Residence of Decedent or 28a-f show ms 23a or 28a-f shormust be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 2511 Painter Court permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No WW I I
Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married ģ 1 ☐ Yes 2 🕅 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Auto Parts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter J. Smith Mary M. Hosken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy D. Smith/Wife 2511 Painter Court, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🕅 Burial 2 🖊 Cremation 3 🗆 Removal from State Maryland Vet. Cem. 12/17/2010 | Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater. Part 1. Enter the disease, of complications that ga Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown signed by the ad be detached to g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 e Hospital or Attending Physician: The law requires the fours after death.

24 hours after death.

24 hours after death.

25 hours all birector. After this certificate has been sign eled filled in by the funeral director, page 2 should be leted filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🗷 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 \square Pending 1 Yes 2 🗌 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 □ only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Riedinger, M.D. 8601 Veterans Hwy., Millersville, MD21108 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Physician/ Medical 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner Anne Arundel Harwood Mandrin Hospice House Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** Davs Hours July 6, 1952 Months 58 Virginia Director 158-42-8354 Usual Residence of Decedent 28a-f show 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'Is marked other than "natural" or items 220 or 200 or 100 o 10c. City, Town or Location 10a. State 10b County Examiner must be notified at Director 1 Tes 2XXNo Annapolis Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21409 Funeral 1285 Swan Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Project Manager Construction 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Ellen Jures Robert Fredrick Sumrall, Sr. permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1285 Swan Drive, Annapolis, Maryland 21409 Melanie C. Sumrall/ Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State 12/15/10 Edgewater, MD Kalas Crematory 4 Donation 5 Other (Specify) vice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line ONTH Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (bride a consequence of): il or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has I filled in by the funeral director, page 2 s 2 No 1 🗌 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie M. Ical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ertifying Nurse Practioner: To the best of my knowledge, death occur 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOOT-TAYLOR filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U | U For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December 6, 2010 Physician/ 5:50 A M Gretchen Irene Satchell Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Genesis Eldercare Spa Creek Annapolis 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 1 □ M 2 K F Hours Month 25/1915 Pennsylvania 95 Director 212-44-0354 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 20c once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Annapolis Maryland Anne Arundel 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 719 Warren Drive 21403 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Specify: White 1 Yes 2 X No Specify If Yes, Give Year or Dates 3 K Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Music Teacher Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Bertha Sayers Thomas Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 79 Summerfield Dr, Annapolis, MD 21403 Kent Satchell - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a, Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Spring Hill Cemetery 12/9/2010 | Easton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or resulting in death) Last a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Year in the past 12 months?
1 Yes 2 No Month Day 1 Yes 2 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 Ho ☐ Yes 2 ≥ 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 **X**No Hospital Other: 1 Tyes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D53111 06 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS, MD 2007 COCON TIDEWATER

State

Registrar

8 2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 7:00 AMM DECEMBER WILLIAM BAYARD SUTTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 217 PHILOSOPHERS TERRACE KENT CHESTERTOWN 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 F Months Hours Min. 12/09/1914 MARYLAND **Director** 212-10-0703 96 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 No CHESTERTOWN MD KENT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21620 UNITED STATES 217 PHILOSOPHERS TERRACE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: item 27 is marked other than "natural", other traumatic event, the Medical Exa Specify: Completed 3X Widowed 4 ☐ Divorced WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working J Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEER TELEPHONE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ပ MYRTLE DURDING permit. Page 1 and 2 should be Department of Health and Menr Important: If item 27 is marke any injury or other traumatic JOSEPH B. SUTTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26050 BESSICKS CORNER ROAD STILL POND, MD 21667 NANCY MILLER/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHESTER CEMETERY 12/23/2010 CHESTERTOWN, MARYLAND Signature of Funeral Service Lice 23a. Palt 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a sthe burial-1 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the b st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier 29b. Signatu 60060301 5 and address of person who completed ca of death (Item 23a) (Type, Pant) ld 5055 CHSSDXIDEN, MD

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Douglas \mathbf{A}^{M} Sturgis 2010 4:40 December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Worcester Berlin Berlin Nursing & Rehabilitation Ctr If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 6 Sex **Funeral** ^{Year)} 1912 Feb. 15 unknown Days Hours Min 1 M 2 X I 98 213-05-3158 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c, City, Town or Location Funeral Director MD Worcester Berlin 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9715 Healthway Drive 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status unknown 14. Race - American Indian Black White etc. Yes 2 X No Yes, Give 1 Never Married 2 Married Completed by Sturgis, Douglas Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: black Specify. 3 Divorced 4 Divorced Year or Dates It of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical I 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) nd Mental Hygiene, marked other than Elementary/Seconday (0-12) unknown College (1-4 or 5+) Page 1 and 2 should be filed within intent of Health and Mental Hygiene, ant. If item 27 is marked other than unknown unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 Progressive Circle Suite 100, Salisbury, MD21804 Donna Blackwell p.r. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 A Cremation 3 Removal from State Crematory of Delmarva 12/9/10 Delmar, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signatur / Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part l Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical ence of ue to (or as a conse Examiner 10 Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy perforn death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signatu and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Healthway Drive, Berlin, MD 21811 Pennie Savage . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistraMEND#26perMD, 12/13/10, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Month Physician/ William Rodney Spicer, Jr. December 8, 2:43 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13517 Georgia Avenue, Apt. 202 Silver Spring Montgomery 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours (Month, Day, Year) ec. 17, 1946 Country) Washington, DC Director 577-62-7848 63 Dec. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗷 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13517 Georgia Avenue, Apt. 202 20906 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1X Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Year or Dates. **Vietnam** 3 Divorced 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Press Operator Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Rodney Spicer, Sr. Pauline Alton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Rapposelli/Sister 3512 Farragut Avenue, Kensington, MD 20895 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date Dec. 10, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2010 Alexandria, VA Signature of Funeral Service L 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Sprin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) signed by the attending physician and deed by the attending physician and deed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Yes 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to de ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗹 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed After this certificate 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending Investigation Accident within 24 hours after death To the Funeral Director. 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 2010 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8109 31. Date filed (Month, Day, Year) Registrar's Signat State 13 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DEC 12, **Physician** 2010 A^{M} 2:30 Fructuosa Colon Medina de Sosa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 17752 Chipping Ct. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 ☐ M 2 🗓 F 93 Yrs 131-24-8330 APR 22, 1917 Director Puerto Rico Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other then "natural", or items 23e or 28e-f show treumstic event, the Madical Examinal must be notified at 1 ☐ Yes 2 X No Director Maryland | Montgomery 01ney 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17752 Chipping Ct. 20832 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hyglene. am 27 Is marked othar than "natural", or Ita 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify:
Puerto Rican 1 Ty Yes 2 □ No Specify: ģ White 3 √2 Widowed 4 □ Divorced eted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compl Elementary/Secondary (0-12) College (1-4or 5+) 6 Machine Operator Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isabel Medina Bosques Manuel Colon Acecedo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar treu once. Nery Lobocchiaro/Daughter 17752 Chipping Ct., Olney, MD 20b. Place of Disposition (Name of comptery, commatory or other place)
Monte Cristo 20c. Location - City or Town, State 20a. Method of Disposition 1 🖁 Burial 2 ☐ Cremation 3 💆 Removal from State

' 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 12-13-2010 A uadilla P.R. 22. Name and Address of Facility Thibadeau Mortuary Service, p.a. 7 Park Ave., Gaithersburg, MD 20877 21. Signature of Fugeral Service Licensee M00956 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Malt Physician disease or condition resulting in death) /Medical Examiner Esquentiary let conditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No
9 Unknown Month signed by the atte 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2× No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Dast 28a. Date of Injury (Month, Day Year) 28d. Decribe how injury occurred After Hospital or Attanding 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division of Vital Records, P.O. Box 68760,

To the

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year)

lary Ellen

29b. Signature and title of certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0061645

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death)ay 2010 Physician/ SHARON SUE SUTTON DECEMBER 11:40 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 510 WILL SMITH ROAD **HENDERSON** QUEEN ANNE'S Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** AUG. 12, 1953 Months Min 1 □ M 2 😿 F 57 Director Yrs. MARYLAND 213-60-9342 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🛣 No MARYLAND QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10g. Citizen of What Country? Funeral 510 ALLEN AVENUE 21666 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ρ 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ould be filed within 72 hours aft d Mental Hygiene. marked other than "natural", WHITE 3 Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) AUTO SALES AUTOMOTIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WILLIAM EDWIN MORRIS, SR. ETHEL GREESON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSHUA B. SUTTON/SON 128 MAIN STREET, STRASBURG, PENNSYLVANIA, 17579 item 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 200 Place of Disposition (Name of CHESAP/EAKE) CREMATION DEC. Dag. 1 Burial 2 XCremation 3 Removal from State 2010 CENTER 4 Donation 5 Other (Specify) STEVENSVILLE, MARYLAND Signature of Funeral Service Lice PEMBOWS gor TELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be SISTER'S Hospital: Other: 2 No ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (SRES/IDENCE 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined

Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t **Division of Vital**

Box 68760

P.O.

Registrar

Medical

29a. Certifier (Check

29b. Signature and title of certif

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONCOLOGY, 2001 MEDICAL PARKWAY, ANNAPOLIS, MARYLAND 21401 ANNAPOLIS

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0064852

29d. Date signed (Month, Day, Year)

12/7/2010

29c. License number

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 per Phy G911 1/26/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dec . 11,2010 3. Time of Death Physician/ Alfred Eugene Swain Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Washington County Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Nov. 1929 Maryland 219-20-3324 81 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director Maryland Washington County Maugansville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13825 Maugansville Rd. 21.767 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian rmed Forces?
X Yes 2 1 Black White etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates. 3 X Widowed 4 □ Divorced Completed I Hygiene. other than "natura rent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Electrician and Mental Hygien is marked other tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Charles Swain permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic eoce. Mary Delauney Swain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roin Davis-daughter 17721 Bluebell Dr. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12-17-2010 | Hagerstown, MD Rest Haven Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myouare disease or condition Medical resulting in death) **∠**Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the burial-transit Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of has autopsy death? After this certificate 2 1 N 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of D 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred atural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Gentining Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, gate and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifier 12-14-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DH 15+1 m BAOSA, TO EHA GERLITOWN M 31. Date filed (Month, Day, Year) 32. Egistrar's Signature State **DEC 17** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Leroy STONE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug • 21 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 XM 2 □ F Months Days Hours Director 67 250-64-3568 943 Usual Residence of Decedent 28a-f show 1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene of Health and Mental Hygiene fitten 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Washington Hagerstown 1 🕅 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 Burger Avenue 21740 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1963-65

If Yes, Give
Year or Dates.1970-75 Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Painting Contractor Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Mertle Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lula Stone - Wife 11 Burger Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 12/14/10 Hagerstown, Maryland . Signature of funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home Talut 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Dus to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23h. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as performed? Yes 2 → No Director: After this certificate I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifier 00054451 15,2010

State

Registrar

Jefferson Blvd Smithsburg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

			1 - For State Registrar	te of Maryla		artment of F rtificate of		Mental Hy	/giene	10	4179		
	Physic	on	Decedent's Name (First, Middle, Last)					2. Date of De	eath	V	3. Time of Death		
7	Physic /Medi			C. Sheet	S			Decemb	er 19,	2010	6:30 p ^M		
_	Exami	ner	4a. Facility Name (If not institution, give street a 149 Oakwood Road	nd number)			r Location of Deat	h	4c. Coun	ty of Death	. 1		
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	Owingo If Under 24 Hrs	8. Date of Bi	of Birth h, Day, Year) Cecil 9. Birthplace (State or Foreig Country)				
	Director		174-30-1593 1X M 20	[□] F 73	Yrs.	Months Days	Hours Min.	Oct. 18	ay, Year) 3, 1937	Coun	nsylvania		
	and		Usual Residence of Decedent 10a. State 10b. County	10c	City, Town or Lo	cation					0d. Inside City Limits		
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	ath wi	ral	149 Oakwood Road				21918		U	.S.A.			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any holury or other traumatic event, it and item Extra instruments in colling at once.	by Funeral Director	1 Never Married 2 Married 1 If Ye	Decedent Ever in led Forces? Yes 2 1 No les, Give r or Dates:		Vas Decedent of H fYes, specify Cuba □Yes 27 No	lispanic Origin? (S an, Mexican, Pueri Specify:	pecify Yes or No o Rican, etc.)		ace - America ack, White, e			
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2	filed w Hygie ther t	S	Eight Years 17. Father's Name (First, Middle, Last)			Logger	18. Mother's Nan	- /Finak & Bidalla		Timber			
Maryland 21215-0036	should be fand Mental s marked of umatic eve	To Be	William J. She	eets			16. Mother's Nan		Caldwel				
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ore	Pages 1 nent of H int: If iter	H	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal	from State	Place of Dispos	sition (Name of natory or other place IO Bapt 1 S	g)	Date	20c. Location	-			
	nit. Pa artmer ortant: Injury B.		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sture of Funeral Service Licensee		Chur	ch Cemete	2rv : 12/	22/10			Maryland		
Ba	permit. Departr Importa any Inja once.		Chaman M. AH	600m	SC LE	Name and Address Pat	tërson & yville,∃	Son Fur	neral Ho	ome, P	.A.		
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the de	ath. Do not ente						Approximate Interval Between		
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	/Medical Examiner		resulting in death)	e to (or as a cons	quence of):						TIMA IIM		
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ŗ.	sician: The law requires that the discriminations are certificate has been signed by the rector, page 2 should be detached	Phy	9 LI UNKNOWN										
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<u>a</u>	ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Deat	1 □ Yes th (Check only o		1 ☐ Yes 2	2 X No		
5 a	hysic this ce al dire	2	1 ☐ Yes 2 ☑ No Hospital:	1 ☐ Inpatient 2 [· · · · · · · · · · · · · · · · · · ·	3 ☐ DOA Othe				ner (Specify))		
5	ding Physician: The h. After this certificate h. funeral director, page	ü	1 ✓ Natural 5 ☐ Pending (Date of Injury Month, Day, Year)	28b. Time of Injury	28c. Injury Work		28d. Describe I	now injury occur	red			
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5	tal or safter safter all Dire	Certification:	4 ☐ Homicide determined	ouilding, etc. (Spec	cify)	or, lautory, office		City or Tov	in, State)	er or Hurai	Houte Number,		
in Hearing	ne nospi in 24 hou he Funer pletely fil	edical	29a. Certifier (Check only one) 1 Certifying Physician: Tr 2 Medical Examiner: On tand	o the best of my kr he basis of examir manner stated.	nowledge, death nation and/or inve	occurred at the timestigation, in my op	ne, date and place pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as sta	ated. the cause(s)		
1	With To I	Σ	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed S SACHDEV M 31. Date filed (Month, Day, Year) 32 DEC 22 2010	ND		29c. License	number 233 22		29d. Date signe	ed (Month, D.			
	7		30. Name and address of person who completed	cause of death (Ite	em 23a) (Type, P	rint)	+ =01	1. ns	12/00	,			
	Stat	e_	31. Date filed (Month, Day, Year)	2. Registrar's Sign	ature E	viegh SI	Lth	11 100 119	1214)				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar #25 & 26, per physician, E.T Certificate of Death12/14/10, 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** 4:50 P Robert William Steele 2010 Dec. 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Worcester Berlin 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 214-18-2122 88 7-31-1922 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Worcester MD Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24 Brookside Drive 21811 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ▼Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 ☑ No Specify: ģ white 3 ₩Widowed 4 Divorced al Hygiene.
d other than "natura
event, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Supervisor Bethlem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Steele Alice Shifford ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5878 Marys Circle Stewartstown, PA 17363 <u>Jan Mitchell-Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State First State Crem. 12-13-2010 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William Street Berlin, MD 21811 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final Physician Myocardial Intavetion disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes signed by the a d be detached f а□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CAD (MI in 4/10) 1 Yes 2 No 3 Probably 4 Unknown Completed Carofid Stenosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 1)X(Yes 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To 27. Manner of Death

1 Natural

2 □ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury ours after death.

neral Director: A
filled in by the fu 1 □ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) D0066169 12/13/10

DHMH 17 Rev 1/2001

5+1 E.T

State Registrar 10445 Old Ocean City Bluet#1, Berlin, MD 21811

Registrar's Signature

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

ela orbix, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:07P M 2010 May Elburn Taylor December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chester River Hospital Center Kent Chestertown 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Hours Min onth, Day, Year) /06/1915 Country)
Maryland Months Director 217-01-5957 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Chestertown MD Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21620 8603 Rock Hall Road United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Russell Cleveland Elburn Alice Virginia Benton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8603 Rock Hall Road Chestertown, MD 21620 <u> Portia Gsell - Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/11/2010 4 ☐ Donation 5 ☐ Other (Specify) Rock Hall, MD Wesley Chapel 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral 130 Speer Road Chestertown, Maryland 23a. Part 1. Enter the disease, a completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final thege mass in Entire Rt lung Physician/ days disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed and-tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death
Unknown Month the 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 N 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA ithin 24 hours after dea...
of the Funeral Director: After thi funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d Date signed (Month, Day, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) within To the 29b. Signature and title of certifier > ////lllum, mo D21313 12/9/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 415 Washington Ave., Chestestown, MD. 21620 Rm WUN, State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black to delib to the East read of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Tonny Tucker 11:45 A M 75/70/5070 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery General Hospital Olney 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min **Director** 156-38-6099 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Charles 10c. City. Town or Location 10d. Inside City Limits Director MD Prince George's Charles Waldorf 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 50P0J AZU 12203 Holm Oak Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 📉 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Sales Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruby Jeter Virgil Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12203 Holm Oak Dr・ュ Waldorfュ MD 20601 M. Janet Tucker / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State New Bethel Church Cem. 12/17/2010 4 ☐ Donation 5 ☐ Other (Specify) Yorktown, VA 21. Signature of Funeral Service 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician RENAL FAILURE disease or condition resulting in death) ACUTE DAYS Medical Due to (or as a consequence of): Examiner LIVER FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi METASTATIC PROSTATE YEAR that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Other (specify) Year 1 Yes 2 No been signed by the should be detached q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by INSULIN DEPENDENT 1 Yes 2 No 3 Probably 4 Unknown DIABETES Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy After this certificate funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျပ 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 ANatural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined thin 24 hours af

the Funeral Di

mpleted filled in ca 29a. Certifier 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

comple only one 29b. Signature and title of certifier မ 29c. License number 29d. Date signed (Month, Day, Year) MD December 10, 2010 D70998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DHANIREDBY OLNEY MD 18101 PRINCE PHILIP DR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Tarke **DEC 2** 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ $\begin{array}{c} {\rm D}^{\rm Month}_{\rm ecember} \stackrel{\rm Day}{10} \end{array}$ Elsie Magnuson Tilman 2010 8:22 a. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dorchester Dorchester General Hospital Cambridge Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Months Hours May Year 928 138-22-4993 82 New Jersey Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Dorchester Cambridge 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21613 915 Talisman Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🖾 No Specify: If Yes, Give "natural", 3 X Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Rouse Charles J. Magnuson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan T. Walker niece 917 Talisman Lane, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Crematory of Delmarva 12/11/10 Delmar, DE 4 Donation 5 Other (Specify) . Signatur 🎶 Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. J 700 Locust St., Cambridge, MD 23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician rentenic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to or as a consequence of it any leading to immedicause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No 24a. Was an autopsy performed? Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certificate: To 1 🗌 Yes 1 XInpatient 2 🗆 ER/Outpatient 3 🗀 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DEC 14

es of person who completed cause of death (Item 23a) (Type, Print)
16M Pair 100 Bramble It. Cambridge, MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joyce Townsend Dec. 9, 2010 1208 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Nightingale House Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours 1 □ M 2 🔀 Months 019-24-7690 Director /1921 29 England Usual Residence of Decedent should be filed within to the Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-1 snown it is marked other than "hadroal Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 Yes 2 K No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20878 Funeral 13004 Darnestown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. 2 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, John Clark permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic Mabel Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Bellucci/Daughter 4100 Erv Court Jefferson, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 12/11/2010 Beltsville, Md 21. Signature V uneral Service Live PHILIPADES PRINALDI FUNERAL SERVICE, P.A Columbia Blvd.Silver Spring, Md20910 9241 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Dementio Book Pnysician disease or condition Medical resulting in death) Due to (or as a con-equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tr<u>gnist</u> Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown iis certificate has been si director, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 (XINo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Coleman 1355 Piccard Rockville 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 13 DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# IperPHYS# 16bperFH, G911, 113/2011, WS
State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registra/AMEND#19aperFH, 12/17/2010, brw, McCo Certificate of Death 's Name (First, Middle, Last)
Icherniak, A.K.A., Anatoliy Chernyak,
Teherniak 2. Date of Death 3. Time of Death A.K.A. Anatoliy Physician/ Dec. 6,2010 0940 М Yakovlevich Chernyak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 12712 Veirs Mill Road Apt.103 Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 3 /25 / 4 946 213-55-6486 64 Russia **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Rockville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12712 Veirs Mill Road Apt.103 20853 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify White Specify 3 X Widowed 4 ☐ Divorced Completed er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Scientific Research College (1-4 or 5+) Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha ury or other traumatic event, the N Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Yakov Tcherniak Hava Tcherniak 19a. **Tigggr**s Nam**@Neimhw&k** *Print)* Egor - Tcherniak / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2087420213 Shipley Terrace #302 Germantown, Md Department of Health Important: if item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 12/13/2010 Chesapeake Crem. 4 Donation 5 Other (Spenty) Beltsville, Md. of Funeral Service Jaconsee PHILIPADE RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Cardiovascular disease disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): re attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No the g Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ history of stroke 1 Yes 2 No 3 Probably 4 Unknown Completed peen hyperlipidemia 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed? Yes 2 2 No 1 Yes 2 No nours after death.

neral Director: After this certificat

filled in by the funeral director, pt Be 25. Was case referred to medical 26. Place of Death (Check only one) xaminer? Hospital 2 \square No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No. ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State, within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Surmar nna D0052832 Dec.10,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

This B Charman MD 1396 Piccard Drive Rockville, Md. 31. Date filed (Month, Day, Year) Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December 13 JOSEPH HENRY THOMPSON 0010 Medical ounty of Death Parility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARLES EDICAL ENTER LATA If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) **Funeral** 1 **X** M 2 □ F Months Hours Min Days AUGUST 8. 1919 Director 214-16-7747 91 MARYLAND Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MARYLAND BRYANS ROAD CHARLES 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2549 MARSHALL HALL ROAD 20616 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

X Yes 2 No 1941 Black, White, etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: BLACK 3 Divorced 4 Divorced 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12TH GRADE MAIL CARRIER FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. WILLIAM HENRY THOMPSON ETHELDRA MARBURY THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONNIE THOMPSON / WIFE 2549 MARSHALL HALL ROAD, BRYANS ROAD, MARYLAND 20616 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1) Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CHURCH CEMETERY DEC. 21, 2010 INDIAN HEAD, MARYLAND 21. Suprature of Fundral Service Liver see THORNTON FUNERAL HOME, P.A. LYDIA C. THORNTON JOHNSON M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying su shock, or heart failure. List only one cause on each line. as cardiac or respiratory arrest. Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as attending physician and for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year signed by the a Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? þ **€**Yes 2 No 3 Probably 4 Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has to director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Tes Impatient 2 SR/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 5 Pending 1 Yes 2 No n 24 hours after death e Funeral Director: A leted filled in by the fo Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nayse Practioners to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of 🖈 29d, Date signed (Month, Day, Year) DECEMBER 13, 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Date filed (Month, Day, Year)

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. egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}010 Dec. Physician/ 6:39 P M William Robert Tubbs Jr. 12, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) MD **Funeral** 1 XM 2 F Months Director 63 214-52-0432 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Berlin Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with th ment of Health and Mental Hygiene.

Sant If item 27 is marked other than "natural", or items 23a o ury or other traumatic event, the Medical Examiner must be ury or other traumatic event, the Medical Examiner must be Funeral USA 10218 Old Ocean City Blvd. 21811 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2x No ģ 1 Never Married 2 Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Business Owner <u>Mechanic</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Robert Tubbs Sr. Elizabeth May Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11143 Grays Corner Road Berlin, MD 21811 Department of Health Important: If item 27 any injury or other tr once, Ann Taylor-Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 12-15-2010 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery Bishopville, MD of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chroniz Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ff any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exam that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Meumonta 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 12 2010 Physician/ Della Jean Usarv 19:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 602 Observatory Dr. Washington County Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Dec 23 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 💢 F West Virginia 233-52-3553 Director 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? by Funeral 602 Observatory Dr. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Henry Moats <u>Orpha Beatrice Cleavenger</u> 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Paul M. Usary-husband 602 Observatory Dr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 12-14-2010 | Smithsburg, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License 1331 Eastern Blvd. North Hagerstown, MD 21742 nillen Part 1. Enter the disease, or consilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atheroselevosis Physician/ disease or condition resulting in death) caes Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or Injury Examine Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No یرے fes یا 1 g □ Unknown 9 Unknown Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law performed 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatu and title of certifi 056783 Jeffrey Hurwitz 30. Name of death (Item 23a) (Type, Print) 5H-5 Hacerstown MD 31. Date filed (Month, Day, Year) State 1 Registrar

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	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea		2, 2ď°aro	3. Time of Death					
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	Examin	ei	6618 Nahal Drive	,		Frederic				Frederick						
	Funeral Director		5. Social Security Number 579–14–0279 6. Sex 1 M 2 💁 F	7. Age (In yrs. last bit	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da Jan • 4	Year) 191	9. Birth Cour	place (State or Foreign ntry) VA					
	and show	'n	Usual Residence of Decedent 10a. State 10b. County		10d. Inside City Limits											
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			23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset ar													
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Division of Vital Records,	al or Atten	Certificate:		e of Injury - At home, ing, etc. (Specify)	farm, stre	et, factory, office		28f. Location (\$ City or Tov		Number or Rura	al Route Number,					
_	To the Hospital or Attend within 24 hours fler death To the Funeral Lirector A completed filled in by the f	Medical	29a. Certifier 1 Certifying Physician: To the be conly one) Certifying Nurse Practioner:	sis of examination and	l/or invest	igation, in my opinio	n, death occurred at	the time, date a	and place,	and due to the ca	ause(s) and manner stated.					
	Within Comment	_	29b. Signature and title of certifier / CW	PA.		29c. License	50640		De	e signed (Month,	2010					
	•		30. Name and address of person who completed cau	se of death (Item 23a)		rint) Pam	ela J. E	mas	ila	of 2	אדרו					
	Stat Registra			Registrar's Signature	A											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Robert Washington :29PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 √ M 2 □ F 75 Months Days Hours Min. 11/2/1935 225-40-0081 Director Virginia Usual Residence of Decedent ital Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1504 Van Buren St. NW 20012 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Religious Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other ti Private Industry Years Minister Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert L. Washington Gladys Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1504 Van Buren St. NW Washington, DC 20012 and 2 s Health a Lois Washington/Wife Department of Health Important: If item 2: any injury or other t injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Lincoln N Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. 12/14/10 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, 21. Signature of Funeral Service Licensee Inc. 3831 Ave. NW Washington, DC 20011 Georgia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine IRATORY FAILURE burial-transit Cause (Disease or iinjury that initiated events certificate be executed resulting in death) Last physician the burial DISEASE Physician/Medical as attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Chandhas Eller MD52855

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

Division of Vital

7207-B Hanover Pkw.

Greenbelt, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

Chandra Korapati,

15 2010

31. Date filed (Month, Day, Year)

BEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 2010 5:30 A M <u>Kathleen C. Way</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 308 S. Cherry Grove Avenue Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Country) Maine Davs Hours Min 971671920 **Director** 005-14-9519 90 Usual Residence of Decedent . Page 1 and 2 should be filed within 72 hours after death with the Maryland trinent of Health and Mental Hygiene. The stream 23 or 28a-f show tant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 308 S. Cherry Grove Avenue 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Bookseller Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry P. Chase Therse Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David C. Way/ Son 308 S. Cherry Grove Avenue, Annapolis, MD 21401 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) MD Veterans Cemetery 12/9/10 4 Donation 5 Other (Specify) Crownsville, MD Serge Licensee 22. Name and Address of Facility George F. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospi**tal or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Dause (Discase or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PRESSURE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2XXI 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 1 ☐ Yes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending iniury 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Praciponer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Cheat only on 29b. Signa 29d. Date signed (Month, Day, Year) H0056619 2010 ess of person who completed cause of death (Item 23a) (Type, Print) Name and a Patrick J. Canan 2002 Medical Pkwy., Ste. 670 Annapolis, MD 21401 31. Date filed (Month, Day, Year)

DEC 0 32. Registrar's Signature State 8 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 26 per med cert G914 4/19/11 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death necember Physician/ 2302 Medical give street and number) 4a. Facility Name (if not institution, 4c. County of Death Examiner 4b. City, Town, or Location of Death asto Memoria + Pital albo Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth g. Birthplace (State or Foreign Min. 1**X** M 2 □ F Months Hours 07/16/1934 PENNSYLVANIA Yrs Director 217-36-1171 Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tatt. If item 27 is marked other than "natural", or items 23a or 28a-f sho at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director is 23a or zou-must be notified a 1 ☐ Yes 2 X No KENT SUDLERSVILLE MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral must 826 BUSIC CHURCH ROAD 21668 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Examiner Armed Forces Completed by 1 Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 Widowed 4 Divorced Specify: WHITE Year or Dates th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 MILLWRIGHT CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JESSE SHARP WHALEN FREDICKA SIGEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET WHALEN/WIFE 826 BUSIC CHURCH ROAD SUDLERSVILLE, MD 21668 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) SUDLERSVILLE CEMETERY 12/14/2010 SUDLERSVILLE, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P
130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 21. Signature Funeral Service Licensee 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) CONCY Medical Due to (or as a consequence of): Examiner nochin M Sequentially list conditions, if any leading to in reclaim cause. Enter Underlying Examine as a nons quence of): solverios Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 d as the IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year page 2 should be detached signed by the g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 🖔 Yes 2 □ No 3 □ Probably 4 □ Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 🗆 No Yes 2- No 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ၉ 1 Tes 2 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 2**9**b. Signature and title of certifier 29c. License number 12/9/2010 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDSTON 010 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:15 P M DECEMBER 2010 ETHEL WILLIAMS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours (Month, Day, Yes **Director** MARYLAND 1937 217-36-9200 Usual Residence of Decedent 28a-f shov 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director DC WASHINGTON 1 XYes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? USA Funeral 20019 items 23a 5821 FIELD PLACE N.E. death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important if et m. 27 is marked of ther than "natural", or i movient or other traumatic event, the Medical Examin any injury or other traumatic event, the Medical Examin þ 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. BLACK Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT FOOD SERVICE Be 18. Mother's Name (First, Middle, Maiden Surname)
ET.ENOR WILLIAMS 17. Father's Name (First, Middle, Last) JOSEPH WILLIAMS 19a. Informant's Name/Relationship (Type, Print)
GARRETT B. WILLIAMS/SON 19b. Mailing Address (Street and Number or Bural Route Number, City of Jove State 7ie Socie)
427 XEMIA STREET S.E. WASHINGTON, DC 20032 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ABurial 2 Cremation 3 Removal from State CEDAR, HILL CEMETERY SUITLAND, MARYLAND 12/14/2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical Examiner resulting in death) eumonia Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) executed Cause (Disease or linjury that initiated events physician and the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be in 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 XNo 9 Unknown 9 Unknown as been signed by 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page performed' 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 140 1 🗌 Yes |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 20 0060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

BLVD

nivest

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Charles Franklin Month Wentz, Sr. December 5:09 p 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours May 24, 1938 Director 181-30-7270 72 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Marvland Prince George's 1X Yes 2 □ No Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** with 4011 William Lane 20715-1229 U. S. A. within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' 1 X Yes 2 I If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 2 | No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White Completed 3 Widowed 4 Divorced 1961-64 er than "natur, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with of Health and Mental Hygien item 27 is marked other the other traumatic event, the Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Edward Wentz Violet. Emma Bonser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Mary D. Wentz/Wife 4011 William Lane, Bowie, Maryland 20715-1229 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Mary fand mati ona't 4 ☐ Donation 5 ☐ Other (Specify) 12/11/2010 Laurel, Maryland Park Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should Renal Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las autopsy performed? Yes 2 No certificate ! 25. Was case referred to medical examiner? Be B 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: မ 1 Inpatient 2 KER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 Accident 3 Suicide Investigation 2 🗌 No Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Name and address of person who completed cause of reath (Item 23a) (Type, Print) a v

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	Si	tate of Ma		d / Depa		t of H	ealth a				•		307
	Ohusis		1. Decedent's Name (First, A	fiddle, Last)								Date of Dea Month	ath Day	Year		e of Death
	Physici /Medi		Janice Wall	ace								Decemb	oer Day	3 201	0 7:2	5 A M
**	Exami	ner	4a. Facility Name (If not insti		et and number)			4b. City,	Town, or	Location of	of Death			County of De	ath	
7			871 Bayard						thia		04 11 1	Anne Arundel				
	Funeral		5. Social Security Number 216-44-7429	6. Sex		_	last birthday) 4 Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt	h v. Year)	46 Ma	irthplace <i>(St</i> a Country) rylan	te or Foreign
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	hours after death with the Maryland tural", or items 23a or 28a-f show at Examination must be mailfact at		10a. State 10b. Co			10c. Cit	y, Town or Lo	cation						-	10d. Inside	City Limits
	with the Maryland a or 28a-f show	cto	Maryland Ann	e Arun	nde1	Lo	thian								1 □Y	es 2X No
	or 28	Directo	10e. Street and Number					10f. Zip	Code				10g. Citiz	zen of What C	Country?	
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Maryland 21215-0036	and 2 should be eath and Mental n 27 is marked of er traumatic ev		19a. Informant's Name/Relat			J U J.	19b. Mailir	g Address	(Street a	-	_	I Route Numbe			Zip Code)	
	and 2 salth 27 i	1 8	Norman Wall	ace(Hu	sband)	871	Baya	rd E	Rđ.	Lot	hian,	Md.	2071	1	
Baltimore,	of Herrical		20a. Method of Disposition 1 X Burial 2 ☐ Cremat	an 0 🗆 Dame		20b. P	lace of Dispo emetery, cren	sition (Nan	ne of ther place)	D	ate	20c. Loc	cation - City o	r Town, State	
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Salt	permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "many injury or other traumatic event, Its Ina Inace.		21. Signature of Funeral Ser			MOO	487					Morti				
ш	205 % 9		Harry	D.L.	elge "	11100	/ 7 8	21 W	est	St.	Ann	apolis	s, M	d. 21	401	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as call shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A Due to (or as a consequence of):									cardiac o	r respiratory ar	rest,		Approxir Interval Onset a	Between nd Death		
68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underwring Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a									5		
P.O. Box 6	ires that the death certificate signed by the attending phys d be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 4	yes, outcome Live birth Pregnant at	2 🗀 Fetal	death 3	Ectopic pr Other (sp					2	3d. Date of d Month	elivery Day	Year
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l Rec	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Completed												prior to death?	autopsy findin completion o	gs available of cause of
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	ne Ho n 24 h ne Fur	Medical	(Check only 2 Med one)	cal Examiner:	On the basis of and manner sta	examinat ted.	tion and/or inv	estigation,	in my op	inion, dea	th occurre	ed at the time,	date and	place, and du	ue to the caus	
	To the vithing To the Congression of the Congressio	Z	29b. Signature and title of cer	tifier				29c.	License	number		:	29d. Date	signed (Mor	nth, Day, Year)
			Kanen	wer	Les				D52730 December 3, 201					010		
0	Sy S		30. Name and address of per Jeanine U	son who comple) RNR/	ted cause of de	eath (Item	23a) (Type, I	Print)	el	Perc	way	#2101	tm	2011	SMO	21401
29b. Signature and title of certifier 29c. License number DS2730 December 3, 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) DEC 0 9 2010 Resistrar's Signature A parks A pa															,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Month Deloris Kidwell Woodward 8:24 p M December 8, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, 1) 9. Birthplace (State or Foreign **Funeral** Days 1 M 25 F Country) Director 577-28-8848 89 1921 Indiana Usual Residence of Decedent shov within 72 hours after death with the Maryland at 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified 1 Yes 2 K No Bryans Road Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2145 Boxwood Circle 20616 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant AAA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic ever 7 is marked of ပ္ Joseph S. Kidwell Alma A. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2145 Boxwood Circle, Bryans Road, MD 20616 Julia K. Satterfield/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 MBurial 3 ☐ Cremation 3 ☐ Removal)from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. Gate of Heaven Cemetery 2010 Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature Funer I Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Lung Nobule Suspicious for Cancer
Due to (or as a consequence of): Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Delotis Kidwiell Wlackward ivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, COPD, Aortic Aneurysm 1 XYes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Tes 2 XNo 1 Inpatient 2 FER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) IC andos D25344 Dec. 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert J. Ginsberg, MD 3905 National Drive, #220, Burtonsville, MD 20866 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

13 2010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month December 13, 2010 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11:34 Am Edward Weidner, Jr. Charles /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Golden Living Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) 936 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F 74 Yrs Director Mary1and 214-34-2424 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene. Lother than "naturel", or iteme 23s or zeen event, its Maulical Examiner must be natified at 1 XYes 2 No Directo Hagerstown <u>Maryland</u> Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after deeth with 21740 750 Dual Highway U. S. A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Dyes 2 No Army If yes, Give Year or Dates: 59-62 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10th Grade College (1-4or 5+) Construction Carpenter permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itsm 27 is marked oth, sny injury or other traumatic event 906a. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Edward Weidner, Sr. Bertha May Davis ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18902 Geeting Road, Keedysville, Maryland 21756 Charles I. Weidner 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 12/15/2010 Frederick, Maryland 4 Donation 5 Other (Specify) Stauffer Crematory 21. Signature of Funeral Service Licensee Bast Stadffe Facilianeral Home, P.A. 7606 Old National Pike, Boonsboro, Md. 21713 Jonald tatteme 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DYDNAYY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and ched for use as the burial-transit To the Hospital or Attending Physicisn: The law requires that the death certificate be executed YEN, C Ô Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificete 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Cther: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 2 1 ☐ Yes 2 ☐ No 3 DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1/ Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours efter death To the Funeral Director: , completely filled in by the f 2 ☐ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 1060336 13110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 26 apal ct SH 1+1 Farid Murshed, MD arstow 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

16 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ Month Day 11:31a [™] James Windsor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) 9-18-1936 1 X M 2 1 WashingtonDC **Director** 74 <u>214</u>-36-3740 Usual Residence of Decedent and More than "natural", or items 23a or 28a-f show 'is marked other than "natural", or items 23a or 28a-f show 'is marked other than "hatural", or items 23a or 28a-f show 'is marked other than "hatural", or items 23a or 28a-f show 'is marked or 28a or 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George Upper Marlboro Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 13311 Van Brady Rd 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Prince George Bd College (1-4 or 5+) 12 Grounds Keeper of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John 0. Windsor Sr Leora Brannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Department of Healt Important: If item 2 any injury or other t <u>Audrey Windsor/Daughter</u> <u> Van Brady Rd.Upper Marlboro.Md 20772</u> injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National 12/16/10 Suitland MD 20605 Agrasco, At 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final ryscardia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ng physician ar as the burial-t Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ó in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 I DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending o 24 hours after death.

Funeral Director: Affelded filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 54635 2010 Name and address of person who, completed cause of death (Item 23a) (Type, Print) C State 1 4 2010 Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

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Box

P.O.

Records,

Division of Vital

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Physici		Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death				
Medical Exam	ner	Ralph C. Walls, St. 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	Month December 1	1, 2010 4c. County of Deat	0808 hrs				
		Harford Memorial Hospital	Havre de Grace		Harford					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24	_	MM/DD/YYYY) 9. Bir					
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any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits				
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th the Maryland 23a or 28a-f sho notified at once.	Dire	142 A Caston Nill Board	21078		II S A					
with th ms 23a be notil	era		Vas Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Puer			ican Indian, Black,				
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21215-0036 wild be filed within 7 Mental Hygiene, marked other than	o Be	BAAAAdore Walls 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	Sadio ing Address (Street and Number o	Faga	r City or Town State	Zin Code)				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygers of Department of Health and Mental Hygers (and page 12 in article of other than "natural", or items 23a or 23a-fahe injury or other traumatic event, the Medical Examiner must be notified at once	4	Li Li								
e, No. 1 and Health litem			A. Cooley Mill R osition (Name of cemetery,	Dafe 20	Oc. Location - City or	Town, State				
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Baltimore, Department of He Important: If ite	1	Signature of Funeral Service Licensee 22.	Mem. Gandens 12 Name and Address of Facility Ze	llman Fune	eral Home.	P.A.				
	(23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	23 S. Washington	Street, t	laure de G	race. MD				
Physician (Medical		failure. List only one cause on each line.	the mode or dying, such as cardiac	or respiratory arrest,	snock, or neart	Approximate Interval Between Onset and Death				
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Reco	E			performed 1 Yes 2	d? death? No 1 ✔ Ye	s 2 No				
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Division of Vital tal or Attending Physician is after death. To Director: After this certical in by the fameral direction.	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.			ral Route Number, City				
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Division of Vital Records, P.O. Box 68760, To the Hopital or Attending Physician: The law requires that the death certificate be Within 24 hours after death. To the Purest Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurrence one)								
To th within To th comp	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated, 29b. Signature and title, of certifier	ation, in my opinion, death occurred		Piace, and due to the					
		290. Signature and title of Certifier	O.C.M.E.	1	ecember 12, 20					
		30. Name and address of person who completed cause of death (Item 23a)								
2		Melissa Brassell, MD Assistant Medical Examiner 111	Penn Street, Baltimore, MI	21201						
	ate	31. Date filed (Moath Day Year) JEC 16 2010 32. Registrar's Signature								
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Scott Willard W	/ilsor	Clate of Maryland / Be	partment of Certificate of	f Health and Men	tal Hygiene	3010) 4 8 2			
Physic		Decedent's Name (First, Middle,Last)	<u></u> _		2. Date of Dea	Day Year	3. Time of Death			
Medical Exam	iner	Scott Willard Wilso 4a. Facility Name (if not institution, give street and number)	December Death	Day Year er 10, 2010 4c. County of Death	2310 hrs					
		85 New Bridge Road	JI Deau I	Cecil						
Funeral Director		5. Social Security Number 214-78-0307 6. Sex 7. Age (In yr. 49		irth(MM/DD/YYYY) 9. Bir 5, 1961 Foreig	thplace (State or gn_Maryland untry)					
th the Maryland 23a or 28a-f show any motified at once.	Director	Usual Residence of Decedent 10a. State 10b. County 10c. C Maryland Cecil 10e. Street and Number	City, Town or Locati	ion Sing Sun Tof. Zip Code		10g. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No			
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after death wi al", or items incr must be	by Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 3 Widowed 4 Divorced If yes 2 X No or Dates:	o If Y	is Decedent of Hispanic Origines, specify Cuban, Mexican, Yes 2 No specify:	Puerto Rican, etc.)	14. Race - Ameri White, etc. Specify:	can Indian, Black, hite			
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Lant: Witem 27 is marked other than "nature or other traumatic event, the Medical Exam.	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Twelve Years) 16a. Deceden during mo	it's Usual Occupation (Give kost of working life, DO NOT	use retired)	Jiffy Lube Baltimore	2			
21215-0036 ould be filed within 7 i Mental Hygiene, s marked other than ic event, the Medica	BB	17. Father's Name (First, Middle, Last) Cornelius W. Wilson, Jr. 19a Informant's Name/Relationship (Type, Print)	Maiden Surname) tzgerald	7:- Code)						
MD 2 Ind 2 shoul on 27 is m aumatic	δ.	19a. Informant's Name/Relationship (Type, Print) M. Elaine Wilson (sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 166 Remington Road, Port Deposit, Mary								
Baltimore, Nemmir. Pages I and Department of Healtl Important: Hitem Injury or other trav		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	Date 12/16/10	20c. Location - City or Rising Sun	, Maryland					
		21 Signature of Funeral Service Linensee 23. Part I. Enter the disease, or complications that caused the dea	Ze Ze	lame and Address of Facility e A. Patterso Perryvill	on & Son Fu le, Marylar	neral Home, id 21903-07	P.A. 66			
Physician Wedital	0.0	failure. List only one cause on each line. Immediate Cause (Final disease a. Asphyxia	atn. Do not enter th	ne mode of dying, such as ca	argiac or respiratory arr	est, snock, or neart	Approximate Interval Between Onset and Death			
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	iner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	e of):							
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Records, P.O. Box 68760, The law requires that the death certificate be execut cate has been signed by the attending physician and page 2 should be detached for use as the burial - trai		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 0 U	2 Fet	tal death 3 Ectopic	pregnancy	23d. Date of delivery Month D	lay Year			
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Division of Vital Records, ral or Attending Physician: The law requing alter death. al Director: After this certificate has been sided in by the funeral director, page 2 should t	Completed						copsy findings available completion of cause of s 2 No			
fital sician: is certifi irector,	BB	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatient	26.Place of Death (Residence 6 V Other:	Scene			
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director,	ation: To	1 Yes 2 No 1 impatient 2 2 27. Manner of Death 1 Natural 5 Pending Profund Pr	28b. Time of In FOUND: 2350 hrs		28d. Describe	how injury occurred				
Divis pital or At ours after d seral Direc filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Basemer		t, factory, office building, etc ce	or Town, S	Street and Number or Rur State) e Road, Rising Sun, M				
o the Hos thin 24 h o the Fur mpletely	ledical (29a. Certifier Check only Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination and manner stated.								
T. 18 10 00	Me	29b. Signature and title of certifier Mh. Bramy, Mo		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) December 11, 2010				
3		 Name and address of person who completed cause of death (Ite Melissa Brassell, MD Assistant Medical Exam 		enn Street, Baltimore	, MD 21201					

State 31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

32. Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend I tem 5 per FH G911 1/13/11 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month David Alfred Williams December 2010 7:00 Medical n 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2706 Parallel Path Abingdon Harford If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 947 1 X M 2 □ F Months Days Feb. T 63 Yrs Maryland **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Cecil Perryville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9C Owens Landing Court 21903 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: "natural", Specify: 3 🗓 Widowed 4 □ Divorced White Year or Dates artment of Health and Mental Hygiene.

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injury or other traumatic event, the Medical MD Transportation Authority Hatem Bridge Perryville, Maryland 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) Administ<u>rator</u> Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William W. Williams Catherine Misieikis 19a. Informant's Name/Relationship (Type, Print)
Dawn M. Ledbetter (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2706 Parallel Path, Abingdon, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date West cation-City of Jown, State R.A.Ferris & Co., Inc. 1 Burial 2 X Cremation 3 Removal from State 12/22/10 Pennsylvania 4 Donation 5 Other (Specify) Lee Ad Adras (Erison & Son Funeral Home, P Perryville, Maryland 21903-0766 21. Signature of Funeral Service Lic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 00 01 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to for as a consequence on Examir Cause (Disease or linjury that initiated events resulting in death) Last and as the burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be rin 24 brous after death.

The Funeral Director, After this certificate has been signed by the attending physicis the Funeral Injector. By the three director, page 2 should be detached for use as the burnelted filled in by the funeral director, page 2 should be detached for use as the burnelted. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 X No 2X No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Daughter's Residence Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending 2 Accident 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

comple only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7+1VA MD 9 pria 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of War Hart Paper at the history of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day - 20/0 Physician/ Month Charlotte Ann Wootten A.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSPICA AT THE WICOMICO COASTAL LAKIZ ALIS BUR 5. Social Security Number 216-32-0265 If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X□ F Months Hours Min 6/8/1932 Year) Country) Director 78 MD' Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 306 Holiday St. USA 21826 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕱 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married white 1 Yes 2 No Specify: If Yes, Give Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) High School Cafeteria worker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lee Burbage Lola Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6722 Libertytown Rd. Richard F. Burbage Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/14/2010 Burbage Family Cem. Libertytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Fun A Service Licens 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CHRONK OBSTRUCTIVE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 9 Unknown 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Oo 24a. Was an After this certificate has perform 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accider iniury 5 Pending work?
1 \sum Yes 2 \sum No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) D005 3410 -11-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 HUMM WARY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 12/10/2010^{al} 6:35 a M Ruth Anastasia Young Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Solomons Nursing Center Calvert Solomons Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. Director 038-16-4317 04/07/1927 83 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD Calvert Owings 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a U.S.A. 6380 Dant Drive 20736 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 72 hours after ò þ Yes 2 No 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Nidowed 4 □ Divorced Specify: White 'natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Procurement Officer GSA is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Mary McGee Edward R. Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10600 Ward Road, Dunkirk, MD 20754 Helen Dreibelbis/Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Resurrection Cemetery 12/14/2010 21. Signature of Eureral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Md Blvd., Owings, MD 20736 Lisa M. Mounts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or iinjury that initiated events that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Seknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, 8 26. Place of Death (Check only one) examiner? 2 No Other မ 1 Inpatient 2 I ER/Outpatient 3 DOA Alursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending Natural injury work? 5 Pending Division 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Lactifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Lactifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dew 5 110 Hospital Rd #310, Prince Frederick, MD 20678 Gwyneth Blattau, MD31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER ANDRE 2010 FRANCOIS Medical 11:00A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROCK HALL **KENT** 20892 BAYSIDE **AVENUE** Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Days Hours Director (Month, Day, Year) 03/19/1930 FRANCE 80 177-26-6440 Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD KENT ROCK HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20892 BAYSIDE AVENUE 21661 UNITED STATES permit. Page 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items:
any injury or other traumatic event. the Medical Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ PROFESSOR **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LOUIS FRANCOIS YON ANNA LANGLADE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDRE P. YON / SON REGESTER AVE. BALTIMORE, MARYLAND 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 12/15/2010 CHESTER, MARYLAND 21. Signature of Furieral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, or complications of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Medical Arterioscleratec Cardiorascular Visease Onset and Death disease or condition resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown the 9 Unknown this certificate has been signed by rail director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certificate: To 1 Tes 2 (No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 🔲 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 20 1)0017036 2500 + 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Ross 5/6 Washington Clistatorn Md- 21620 Juson

State Registrar 31. Date filed (Month.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Registrar Certificate of Death Reg. No.														
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Funeral Director		5. Social Security N		6. Sex	7. Age (In yr:	s. last birt		If Under 1 Ye		der 24Hrs.	8. Date of E	,	MM/DD/YYYY) 9. Birthplace (State or Foreign MARYLAND		
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MOre, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Nur 5 SCARI		SE COURT				10f. Zip Code 20866				10g. Citiz USA	en of Wha	at Coun	try?
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Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location -													
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Ba Perm Depa Impe	EVELYN YATES/WIFE SCARLET SAGE COURT BURTONSVILLE, M 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, M														
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											Approximate Interval Between Onset and			
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Division piral or Attendir ours after death. reral Director: A	Certification:	3 Suicide	6 Could		of Injury - At	home, far	m, street,	factory, office b	uilding, et	c. 28	f. Location (or Town, S		d Number	or Rura	Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 (Check only		ysician: To the bes											
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2:00 am Ching Or Yee December 09. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Village Healthcare Center Montgomery Village Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F Director 218-78-5254 11/01/1923 China Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 1 No Maryland Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11513 Kimbark Court 20878 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: ģ 1 ☐ Yes 2 X No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hay Fou Lau ဂ္ Yee Sum Na 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra once. 11513 Kimbark Court, N. Potomac, Maryland 20878 David Yee - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Pk. 12/13/2010 Olney, Maryland 21. Signature of Funeral Service Lights en # 1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home. - 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedime Cause (Final Physician ASZIRATIOP disease or condition resulting in death) Due to (or as a consequence of): FALLOTTE Sequentially list conditions, Examiner di a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) UKSee Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 ZNO 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After after death Director: 24 hours after e Funeral Dire letely filled in b To the Hosp within 24 ho To the Fune completely f

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont of Health and arked other than "natural", or Items 23a or 28a-f show

/Medical

Examiner

Baltimore, Maryland 21215-0036

ed other than "natural", or Items 23a or 28a-f shore event, the Medical Exercities is ust be notified at

31. Date filed (Month, Day, Year) State UEC Registrar

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Anushiravan Dadgar-Dehkordi, M.D., 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 3 2010

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

HOC51280

10110 Molecular Dr., #206, Rockville, MD 20850

29d. Date signed (Month, Day, Year)

12-10-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 154 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 | F Months Days Hours Min 8 8 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Eyaminas mand hard and injury or other traumatic event; the Medical Eyaminas mand hard and injury or other traumatic event; the Medical Eyaminas mand hard and injury or other traumatic event. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 24 No SSISX 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 0.5 A 21226 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan ပ 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number 05% Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 0.1 Sign sure of Jun ral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has [page 2: autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Hospital Other: 2 No 2 1 🗌 Yes within 24 hours after deaun.

To the Funeral Director: After this commieted filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my existed death and place. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar's Signature 05 JAN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Vear Physician/ 1457 M Decembe Andrews -eon 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A BHYVIOW Moderal Center BAltimore Johns Hapkons 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Social Security Number 1 XM 2 D F Months Davs Hours 0/30/1/1 /9//1/1923 MARYLAND 87 215-12-3972 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State Director 1X Yes 2 ☐ No N/A BALTIMORE MD 10g. Citizen of What Country? ō 10e. Street and Number Completed by Funeral U.S.A. 21224 3117 FOSTER AVENUE permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 1 0 4 4 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 XWidowed 4 Divorced Year or Dates 1944 – 46 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) BETHLEHEM STEEL CARPENTER 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည AGNES STODOLNY FRANK ANDRZEJEWSKI Μ. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3117 FOSTER AVENUE, BALTIMORE, MD CONSTANCE ANDREWS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State JESUS 1/4/11 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) SACRED HEART OF 22 Name and Address of Facility R INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ardiovascular Disens Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Heart Failure Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Pressure 24b. Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No Blood 24a. Was an autopsy performed? Yes 2 1 Jas within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Acciden
Suicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0028634

DHMH 17 Rev 7/2009

State

Registrar

Center

Medica

32. Registrar's Signature

4940 EASTERN Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins
31. Date filed (Month, Day, Year)

JAN 05 2011

Bayview

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician George John Bosch, Jr. 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sav **Funeral** Months Days 1 X M 2 □ F 09-30-1920 Maryland 90 Director 213-14-0368 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evandar must be neithed at 1 □Yes 2 🙀 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral 21228 U.S.A. 29 Glenwood Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Postal Service PSDS Technician 12 should be filed with and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George John Bosch, Sr. Mary Resig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau 29 Glenwood Avenue; Catonsville, MD 21228 Rita M. Bosch/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park 01-03-2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Lice see Funeral Home of Catonsville, 1630 Edmondson Avenue: Caton Sock, or heart failure. List only one cause on each line. 1630 Edmondson Avenue; Catonsville, Maryland 21228 Approximate Interval Between Onset and Death Immediate Cause (Final Physician eav OV OV av disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VIUOCOU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) cate nas been signed by the page 2 should be detached Ö 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 1 □ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 patient 2 ER/Outpatient 3 DOA 1 Yes 2 ∆ Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Datural 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check of one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

CA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:05 р м December 29, 2010 Gilbert Brungardt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Julyeth, 3ay, 79930 1 M 2 □ F 80 Kansas 513-28-7552 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Director Baltimore Timonium 1 Tes 2 XNo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21093 205 Belmont Forest Ct., #102 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give Specify: 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) f Health and Mental Hygiene. item 27 is marked other tha Music Education College Dean/Musician Be 18. Mother's Name (First, Middle, Maiden Surname)
Adelia Dre 17. Father's Name (First, Middle, Last) 2 Dreiling Brungardt Ambrose injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 205 Belmont Forest Ct., #102, Timonium, MD 21093 Theresa Brungardt-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. St. Fidelis 1 X Burial 2 Cremation 3 Removal from State Victoria, KS 01/07/2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) a. LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 □ No 3 □ Probably 4X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 24 this certificate has ral director, page 2: 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 1 🗌 Yes 2 X No 읻 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the I Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD, MD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State JAN 05 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 16A M em ber Michael Gaylord Burton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country)UNK **Funeral** Month Day, Days 1 🖾 M 2 🗆 F Hours Director 52 212-11-6962 [an] Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director MT Baltimore 1 🛛 Yes 2 🗌 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 439 E. 27th Street 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by black. 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carl Dickerson Marion Yvonne Burton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Trolod Ct. Apt E; Owings Mills, MD 21117 Anthony Whiting - brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) In State 22. Name and Address of Facility State Anatomy Board icen A Director 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or beart failure. List only one cause on each line Immediate Cause (Final Physician. onvestive disease or condition resulting in death) ears Medical Due to (or as a consequence of): Examiner orti Rars Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) 24 hours after death.

2 hours after death.

e Funeral Director. After this certificate has been signed by the attending physician and Hospital or Attending Physician: The law requires that the death certificate be executed Staa that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death 2 No a I Inknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No ျ 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License numbe 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M

Registrar

32. Registrar's Signature

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 6:36 PM M Ethel Mae Boddie December 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner House of Love Fort Washington Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Mar 28, 9. Birthplace (State or Foreign Country) North Carolina Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 86 Director 243-40-3427 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Prince George's 28a-f MD Fort Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or USA 20744 9813 Jacqueline Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: black à 3 ☑ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th 0 domestic unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.9
Department of Health a
Important: If item 27 is
any injury or other trau 3311 Altair Lane Upper Marlboro, MD 20774 Ruby Armorer/cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4□Donation 5♥Other (Specify) in state 21. Signatur of Funeral Syn yice License 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Approximate Interval Between Onset and Death Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and Due to (or as a consequence of): burialattending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ ★ o Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 2 No 3 Probably 4 Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Hospital or Attending Physician: The certificate 1 □Yes 2 No 1 ☐Yes 2 ☐ No **Division of Vital** 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death

Director: A

d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour. the Funeral Dire 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) npletely and manner stated. the within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fro WASH I MET M MY 1001 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 8:03AM December Herman Bothe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) g. Birthplace (State or Foreign Country) unk **Funeral** 8. Date of Birth Days 1 🗆 M 2 🗆 F Hours Min. (Month, Day, Director 72 Yrs. 219-38-6608 Aug Usual Residence of Decedent shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore Catonsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 Edmondson Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white "natural", Completed 3 Divorced 4 Divorced Year or Dates ed other than "natu 15. Decedent's Education unk unk 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) unk unk Be 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) marked o မ the state of the s 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 S. Caton Avenue Baltimore, MD St. Agnes Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 🛛 Other (Specify) in state 21. Signature of Euneral Strate Licensee Ronal d S walls State and accompanies and 655 W. Baltimore Street Director 21201 <u>Baltimore, MD</u> . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between be heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cardio vasculos disease or condition resulting in death) bue to (or as a consequence of): Atheroscieratic Medical **Examiner** Discase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Dute to (or as a consequence of). honic Obstructive Pulmonar Years that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page ☐ Yes 2 🔽 1 🗌 Yes 2 🗌 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46505 December 13, 2010 warne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Agnes Hospital. 900 Caton Avenue, Baltimer wanmoh

State Registrar Day Year)

31. Date filed (Mo

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-c,e,f per fh g911 1-5-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ Michael Calpin J. 16:10 M 12/24 Medical 10 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** (Month, Day, Year) 1/24/1916 170-09-5850 94 Months 1 🔀 M 2 🗆 F Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a, State Director Lackawanna Scrant ¹X☐ Yes 2 ☐ No MD. Montgomery Potomac 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1028 Park USA 20854 000 10204 Lloyd Road filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? US Army Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. 42-63 Specify: ₩XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) US Army 12 US Army and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Golden Anna 2 Michael Calpin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Nalley / Daughter 10204 Lloyd Road, Potomac MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State St. Catherine Cemetery 12/29/10 Moscow, PA 4 ☐ Donation 5 ☐ Other (Specify) Doda, 722 Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore MD 21230 21. Signature of Funeral Service Licensee Victor P. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ MYC disease or condition resulting in death) Medical Due to (o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ending physician and use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician and be detached for use as the hurial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 sl autopsy performe death?
1 ☐ Yes 2 🛣 No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: 2 X No 1 🔲 Yes ျှ 1 Npatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No **X**Natural injury 5 Pending Accident Accider
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medica Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who com State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ December 37, 2010° 7:30 P M Young Coster, Sr. Robert Medical 4b. City, Town, or Location of Death Bel Air 4c. County of Death Harford 4a. Facility Name (if not institution, give street and number) **Examiner** 4 Seasons Hospice 8. Date of Birth (Month, Pay, Year) Sept. 15, 1918 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. 1 🗶 M 2 🗆 F Months Days Hours Mary Land Sept. **Director** 218-01-2743 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. I limportant if filem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Marical Experience. 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Yes 2 No Bel Air Harford Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21014 601 Thames Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

I X Yes 2 \sum No
If Yes, Give 1043—1946

Year or Dates: 943—1946 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry 12 Marine Draftsmen Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nellie Hoshall Coster Alvin Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21014 Bel Air, Maryland 508 Cesky Place John R. Coster 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Maryland 1-8-2011 4 Donation 5X Other (Special Comment Air Memorial 22. Name and Address of Facility 21. Signa Rick Towson Funeral Home, Inc. Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live large occ.
Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autons death? 25. Was case referred to medical 26. Place of Death (Check only one) Be **Division of Vital** examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify ASS) ST67) 4 VINC 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Ceath 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) ANUSHA Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 18 Physician/ Month 1120 AM Martha Elena Conti December 201C Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Days 1 - M 2 7 F Hours Colombia Director 579-52-9672 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Washington 1 Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 750 Dual Hgwy 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Colombian Latino Specify Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sila Rodriguez Maria Delia Vargas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Bennett/daughter 19960 National Pike #D Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state Signatur Lineral Shace Licensee State and Address Board 655 W. Baltimore Street |Baltimore MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or con micresulting in death) hema Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has | completed filled in by the funeral director, page 2 s autopsy performe 2 X No 2 🗌 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 Papatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 Yes 2 No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5°2011

d

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Kristy 4:36 PM December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death university of mary land medical Cent Baltimore If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months 1 🗆 M 2 😾 F (Month Day, Year) ct 3, 1952 Hours WEst Virginia Director 232-88-7159 58 Usual Residence of Decedent 28a-f shov at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD 1

Yes 2 □ No Baltimore 70 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2121 Wilhelm Street 21223 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. o þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 🔽 No Specify: Hygiene. other than "natural", 3 Widowed 4 Divorced white Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) office manager unk manufacturing Be Page 1 and 2 should be filed in the sent of Health and Mental Hy ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Raymond Keenan Garnet Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Cooper/spouse 2121 Wilhelm Street Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 □ Donation 5 N Other (Specify) in state 21. Signature of Functal Service Licenses Ronald S. Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore. ΜĎ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Pasteurella Medical resulting in death) Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical that the death certificate be the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ò Month Day Year sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ᅌ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 1740489970 ompleted cause of death (Item 23a) (Type, Print) CRNP Hag 22 South Greene Street, Baltmore 31. Date filed (Month, Day, Year)

JAN 0 5 20 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

20

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Physicia

/Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be rotified at once.

Baltimore, Maryland 21215-0036 Physician

/Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Registrar		Certificate of Death	Reg. N	o
an cal	1. Decedent's Name (First, Mi	Antoinette	Cole	2. Date of Death Month D	ay Year 3. Time of Death
er	4a. Facility Name (If not institu-	medical Cen	4b. City, Town, or Location A LAP ATT The state of the	+	9. Birthplace (State or Foreit Country)
Director	Usual Residence of Decedent 10a. State 10b. Cou		City, Town or Location ValorF		10d. Inside City Limi
al Dire	10e. Street and Number	nnister Circle	10f. Zip Code	10g. C	citizen of What Country?
by Funeral	11. Marital Status Never Married 2 N Widowed 4 Divord	If Yes, Give	U.S. 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical 1 ☐ Yes 2 No Specify:		14. Race - American Indian, Black, White, etc.
Completed	15. Dece (Specify only hig Elementary/Secondary (0-1:	dent's Education ghest grade completed) 2) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during mos	at of working	Kind of Business/Industry
To Be Co	17. Father's Name (First, Midd	ile, Last) UNKNOW	18. Moth	er's Name (First, Middle, Maide 249nna La-Ch	infant on Surname) al Backy-Spark
To Be Completed by Funeral Director	19a. Informant's Name/Relati 20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other	a-Chae Bailey-Sa 20b. on 3 □ Removal from State	19b. Mailing Address (Street and Numb ALK Man 202 Bannis 1. Place of Disposition (Name of cemetery, crematory or other place) ARY ARY STATE Anatymus	Greck U	or Town, State, Zip bode) Albert MD 206 Location - City or Town, State Path MRE MO
		S. Nade, Directo	[6] [7]		Itimore Street
edical Examiner	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Due to (or as a consect	equence of):		Approximate Interval Between Onset and Death
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
₽ S	Part II. Other significant cond	ditions contributing to death but not re	esulting in the underlying cause given in Part		o use contribute to the cause of death? No 3 Probably 4 Unkno
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Completed	OF Was appearatored to made	[see]		24a. Was an autopsy performed?	prior to completion of cause death?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-09849 State of Maryland / Department of Health and Mental Hygiene Steven William Custer, Sr Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day December 21, 2010 William Custer Sr. 1136 hrs Steven Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Harford 806 Old Country Court If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days 216-66-8730 Hours 07/11/1954 Country) MD Director 56 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny Bel Air Harford MD 1 X Yes 2 No "natural", or items 23a or 28a-f sho Examiner must be notified at once. 10g. Citizen of What Country? 10f, Zip Code 21014 USA Old English Court Apt.2A 806 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status White, etc Armed Forces? 1 Never Married 2 X Married 2 X No Yes White Specify 1 Yes 2 No specify: 4 Divorced If Yes, Give Year 3 Widowed 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than ""
injury or other traumattic event, the Medical E Maintenance Mechanic Manufacturing 21215-0036 Compl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marian Stricker William Custer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1714 Fulton Street, Harrisburg, PA 17102 Baltimore, MD Steven W. Custer Jr. / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Woodbine, MD 1/3/2011 Final Journey crem. 4 Donation 5 Other Specify Porota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD
PO Box 1413, Baltimore, MD 21203 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician ||Webical Between Onset and failure. List only one cause on each line Death Diabetic Ketoacidosis Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and trans Physician/Medical 23a,pt.II,27 per me g912 2-9-11 vt X UNPENDED AMENDED attending physician or use as the burial law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IE EEMALE 23b. Was decedent pregnant in the 2 Fetal death Month Day 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ç Unknown certificate has been signed by the ector, page 2 should be detached for 23e. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 ✔ Unknown 2 Atherosclerotic Cardiovascular Disease Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certif 25. Was case referred to medical Be Hospital: 1 Inpatient examiner? Other Nursing Home 5 Residence 6 🗹 Other: Scene 2 ER/Outpatient 3 DOA 1 🗸 Yes ۵ 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day,Year) Certification: 1 X Natural 1 Yes 2 No 5 Pending filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 3 Suicide or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sa 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 22, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 0 5 201 2. Registrar's Signature State arks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia	n/	MA						Month	Day	Year	3. Time of Death	
. مـر	Medic		Ronald Crouch						December		2010	11. 40H M	
	Examin	er	4a. Facility Name (if not institution, give str			4b. City, Town, or	Location of	Death			unty of Death	_	
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	Funeral Director		· 1 □	7. Age (In yrs. 7)		Months Days		Min.	8. Date of Birth (Month, Day, 01/28/		Coun	olace (State o <i>r Foreign</i> try) 1 Land	
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	or 28	₫	10e. Street and Number		20202	10f. Zip Code				10g. Citizen	of What Cour	ntry?	
	with 1	eral	2926 Clearview Ave	nue		21234				U.S.	Α.		
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Baltimore, Maryland	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funeral Service License	_		. Name and Addres			atomy C				
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	ne He in 24 ne Fu plete	Mec	(Check 2 Medical Examine only one) 3 Certifying Nurse	r: On the basis of examination Practioner: To the best of m	on and/or inves ny knowledge,	tigation, in my opinio death occurred at th	on, death occ e time, date a	curred at and place	the time, date are, and due to the	na piace, and cause(s) an	d due to the ca	tated.	
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			30. Name and address of person who con	pleted cause of death (Iter	m 23a) (Type, F	Print)	D.14".	20	111. 7	1200			
_			30. Name and address of person who con			S- (03.	Dalin	11016	11/10. 5	1209	1		
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	Registr	ar	JAN 0 5 20	11 Amount	B. 36	Jarket -							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 1 11:20PM Antoinette Clark Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 6603 English Oak Road Parkville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 6. Sex 7. Age (In vrs. last birthday) Days 1 □ M 2 🏻 F Hours (Month, Day, Year) 04/10/1950 Maryland 218-48-1793 Director 60 Usual Residence of Decedent "natural", or Items 23a or 28a-f show edical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Parkville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6603 English Oak Road 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 **K** No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Divorced Year or Dates 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Representative Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilkins Saunders Anna permit. Page 1 and 2 should Department of Health and M. Important; If item 27 is mar any injury or other traumati once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muro Basilio / Son 5900 Glenore Road, Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ■ Donation 5 □ Other (Specify) Anatomy Gifts Registry 01/03/2011 Hanover, Maryland 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician CANCER Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ò Month Day Year Pregnant at time of death certificate has been signed by the a rector, page 2 should be detached f g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 1 🗌 Yes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) director 2 **V**/lo Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death
1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 0

CEKEN, NO 6169 N. CHAKES

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8-14 AM Naomi I. Corbin 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5. Social Security Number 10 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 🔀 F 80 Director 212-28-6082 7/6/1930 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show event, the Medical Examinar nust be notified at 1XYes 2 No Director n/a Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21230 USA 2803 Washington Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. Completed by Specify: White 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If item 27 is marked other any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louise Ingram Charles R. Hoffman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1370 River Mist Court, Baltimore, MD 21226 Ann Ebberts / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 1/4/2011 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Figrature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) 1 Bleed **Physician** nupowon /Medical Due to (or as a consequence of): Examiner Unknow Luk -Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 12/No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Medical Certification: To 1 ☑ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No nours after death.

neral Director: / investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hoi **To the Fune** completely fi (Check only one) 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Medica 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 s catan ave, Darsesa, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

VOID

CERTIFICATE

2010-41835

SEE

CERTIFICATE #

2011 - 03420

Velma Elizabeth Delgado

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2

<i>,</i> ,		
State of Maryland	/ Department of Health	and Mental Hygiene

		1- For State Registrar		(Certifica	te or	Death			R€	g. No.		
Physicia Podical Examin	ın/	7 1. Decedent's Name (First, Middle,Last) 2. Velma Elizabeth Delgado							. Date of Deat Month December	Day Year 24, 2010		3. Time of Death 1341 hrs	
1-6		4a. Facility Name (if not institution 7978 Solley Road							of Death		4c. County o		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In	yrs. last birth	day)	If Under 1 Year Months Day				h(MM/DD/YYYY	Foreig	n
Director	-	220-74-0259 Usual Residence of Decedent	1 M 2 F		49	Yrs.				June 3	, 1961_	Not	rth Carolina
and show any nce.		10a. State 10b. County			City, Town o								10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	Director	Maryland Anne 10e. Street and Number	Arundel		Glen B	urnı	10f. Zip Code			10	og. Citizen of Wh	at Cour	ntry?
h the N		7978 Solley					21060				United		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-fabor other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 M	larried Armed F	2 X		If Ye	s Decedent of Hi es, specify Cuba	n, Mexican	, Puerto Ri		- 14. Race White		can Indian, Black,
rs after	<u>a</u>	3 Widowed 4 X Div	vorced If Yes, Give Ya or Dates:		ed) 16a. D		Yes 2 X No			rk done	Specify: 16b, Kind of Bus		hite ndustry
5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)			ost of working life						,
5-0036 iled within 77 Hygiene. d other than the Medical	E E	7				Disa	abled	40 14-45	d- No //	That Baladalla B	N/A		
215-00 be filed wit ntal Hygien rked other ent, the Ma	Be Co	17. Father's Name (First, Middle Abner M. Pe							,	t T. Bi	Maiden Surname) Cock		
Should be fill and Mental F 7 is marked		19a. Informant's Name/Relations			19b.	Mailing	Address (Stre	et and Nun	nber or Ru	ral Route Num	ber, City or Town	, State,	Zip Code)
ore, MD 2 ss 1 and 2 shou of Health and N If item 27 is n her traumatic		Jamie Perry / D	aughter	T			Meade C			Apt. 3	369 Sev 20c. Location -	ern :	MD 21144 Town, State
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other fraun		1 Burial 2 X Cremation				•	ner place)		10/0	0/2010	Cohonou		. Maruland
Baltin permit. Pa Departmen Importan injury or	ł	4 Donation 5 Other Si 21. Signatur of Funeral Service			Metro	Crei	matory	s of Facilit	12/3	0/2010 oral Ho	ome, P.A	TTT	e, Maryland
		23a. Part.I. Enter the disease, or	<u></u>		looth Do not	42	l Crain	Hwy.	SE;	Glen H	Burnie,	MD_	21061 Approximate Interval
Physician Medical	Į	failure. List only one cause	on each line. Me t				henhydra						Between Onset and Death
<u> </u>		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	a consequer	nce of):								
	5	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequer	nce of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as	a consequer	nce of):								
ecuted and - transit		events resulting in death) Last	d										
760, cate be exe physician a	n/Medical	☑ UNPENDED	AMENDED 23a,	27, 2	8a-f p	er l	ME G911	1/11,	/11 M	AM			
18760, rtificate being physic as the buri	N N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	he 23c. If yes,	, outcome of birth	pregnancy 2			Ectopi			23d. Date of Month	-	ay Year
Box 687 e death certific the attending ped for use as t	Physicia	1 Yes 2 No 9 V Uni		nant at time nown	of death 5		ner (Specify)						
i, P.O. Boires that the de signed by the lede detached f		Part II. Other significant condit	ions contributing	to death but	not resulting	in the u	inderlying cause	given in Pa	art I.				the cause of death?
S, P	ed by	-								1 Yes			ably 4 Unknown
Records, The law require ficate has been signaled.	Completed	-							_	autop perfor	sy p m <u>ed</u> ? d		ompletion of cause of
tal Rectino: The certificate ector, page		25. Was case referred to medica	Al .				26.Plac	e of Death	(Check on		2 No 1	Ye	s 2 No
of Vital ng Physiciao: After this certi	To Be	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2		·		Other ₄			Residence 6	_	: Scene
~ = ^ ≥		27. Manner of Death 1 Natural 5 Pene	+ Mon	e of Injury th 2 av Xear)/	28b. Ti	1:2:	_	uryat Work Yes 2 🏻	1	8d. Describe h un	now injury occurre k.	ed	
Division Lal or Attendiu To after death Lal Director: A	ficat					m, stree	et, factory, office		tc. 2				ral Route Number, City
Divis spital or At nours after d neral Direc filled in by	Certification:	4 Homicide dete	rmined (Specify	hous									en Burnie,M
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		thysician: To the beaminer: On the basis	of examinat									
To with	Me	29b. Signature and title of certific	and manner er	stated.			29c. Licen	se number			29d. Date signe	d (Mor	nth, Day, Year)
		Milyania ?	me Clour	l			0.0	.M.E.			December	25, 20	010
end		 Name and address of person Margarita Korell MD. 	n who completed car Assistant Me			111 Pe	enn Street, E	Baltimore	e, MD 21	1201			
	ate	31. Date filed (Month, Day, Year)	- 2	Registrar's Si	gnature	Kast	,						
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DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John O. Frederick, Jr. 7:50 P M December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 28, 1 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 XM 2 I Months Hours Min. Country) Director 218-10-3253 91 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Woodlawn 1 Yes 2 No 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? 23a Funeral 6811 Campfield Road 21207 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 ρ 1 Never Married 2 Married 1 X Yes If Yes, Give 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. White "natural" Completed 3x Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Pipe Fitter Shipwright Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 Is marked o John O. Frederick, Sr. Anna Mae Imhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Jennings 459 Glen Mar Road; Glen Burnie, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
ake View Mem. Park 20a. Method of Disposition 20c. Location - City or Town, State Important: If i any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/6/2011 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Leer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death n signed by the a 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed CONSTON 1 TYes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an ate has t autopsy perform Yes 2 certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 🗆 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check í 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WILLIAM FRANKLIN 12 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NARSING Home FUTURE CARE (LOCHEARN) BALTIMORE Baltimore 8. Date of Birth (Month, Day, Year) Aug 30, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 € M 2 □ F Months Hours Min. Virginia Director 213-18-3426 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 X Yes 2 No Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 21217 USA 1520 W. North Avenue 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ⋧ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: black. Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education unk 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) steelworker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Franklin Earl Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4023 Cutty Sark Road Baltimore, MD Kim Moore/granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ♥ Other (Specify) in state 21. Signature of Euneral Service Licensee Ronald S State and Address of Facili Board 655 W. Baltimore Street 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Dechne disease or condition resulting in death) Medical Due to (or as a consequence of) ⁴Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical that the death certificate be Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 M:Nursing Home 5 A Residence 6 A Other (Specify) 1 Yes 2 × No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Division 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

MD

821

62. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

SHOAIB A. HASHMI

31. Date filed (Month, Day, Year)

31464

N. EUTAW ST Finte 300 BALTIMORE MD 21201

12/1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (Firşt, Middle, Last) 2. Date of Death Physician/ DEAVER Month 2250 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARY LAND MEDICAL CENTER BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year if Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🗆 F Days Hours **Director** 11/10/1953 216-62-8850 Usual Residence of Deceden or 28a-f shov 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland must be notified at Director 10d. Inside City Limits 1X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21217 USA 1710 N. Mount Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status unk 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give unk Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 🗓 No Specify. 3 Divorced Specify: Year or Dates 15. Decedent's Education un 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withii Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the lonce. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 S. Greene Street Baltimore, MD University of MD Medical Ctr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state Signature of Funeral Service Licensee Renaid State and Address Board 655 W. Baltimore Street Nivector Baltimore, MD 21201 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Interval Between HYPOVOLEMIA Immediate Caus I inal Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 5 HOVES ADRIC RUPTURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine 5 HOURS A ADETIC DISSECTION Cause (Disease or iinjury that initiated events resulting in death) Last TOUTE TYPE Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 2 \square No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 📈 No Other: မ 1 Tyes 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pendina 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a

To the Funeral C

completed filled i Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

ERIC

31. Date filed

GREENE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOUTH

32. Registrar's Signature

LEYR

Year)

2011

) 5

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STREET

BALTIMORE MA

State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 31, 2010 Physician/ 10:07AM John W. Guillott, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 F Months Days Hours (Month, Day, Year) b. 23 1926 Mary Land **Director** 212-20-4305 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Md. Baltimore Timonium 1 🗌 Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Funeral 23a 21093 USA 2141 Suburban Greens Dr. or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Yes 2 □ No If Yes, Give Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural", 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Business Owner Food Service and Mental Hygie is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edith Wallis injury or other traumatic Walter Guillott 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is <u> John W. Guillott,</u> Jr./ Son Woodfork Rd. Timonium. Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 1-5-11 Timonium, Md. 21. Signature of Fuperal Pervice License 22. Name and Address of Facility Son Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ JChemic disease or condition resulting in death) mvann Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed bunial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician use as the burial Physician/Medical P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death signed by the a a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has autopsy this certificate 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes ၉ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 28d. Describe how injury occurred After work?
1 Yes 2 No iniury 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) within 24 hours a

To the Funeral D

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) D0060248 and addless of person who completed cause of death (Item 23a) (Type, Print) haves Arcet Balkmore, MD C. Greenanalt State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 📋 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2010 8:20 P M Loretta A. Glatz Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Gregoria Court N/A Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Hours (Month, Day, 1942 New York 68 Oct 136-34-0282 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director N/A Maryland Baltimore 1

Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 U.S.A. Gregoria Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James B. Allan Lechien Dorothy L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21212 Robert Glatz / Husband 14 Gregoria Court Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/7/2011 Hilltop Service Corp Towson, Maryland 21. Signature of Fundation Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Interval Between
Onset and Death Breast Immediate Cause (Final Metasta Physician/ year disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the a 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 \square Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 🗌 Yes 4 🗆 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ only one 03/11 and address of person 71204 Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 December 11:35 PM™ Kelly Galinus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richey Hospice Baltimore 8. Date of Birth Apr 5, 1972 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 F Hours Mary land 219-76-3307 Director 38 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Marker. 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 ☐ No Brooklyn Park MD 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21225 825 Freeman Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 💢 No If Yes, Give Maryjand 21215-0036 white 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation un 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Richey Hospice 828 Eutaw Street Baltimore, timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state Sig atto- of Funeral Service Licensee Bai 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21201 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician metastatic breast disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Tyes 2 No 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 3 Probably 4 Unknown 1 🗆 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical Division of Vital Certificate: To Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} Other: 4 Nursing Home 5 Residence 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 107936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimore, MD Menino Day, Year) 0 5 2011 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 📗 📗 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HORNE ANN Month ELIZABETH 8:55PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death COLUMBIA HOWARD COUNTY GENERAL HOSPITAL HOWARD Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X F Hours SEPT. 16,1940 217-38-9166 Director 70 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? by Funeral 9113 East Stayman Drive 21042 12. Was Decedent Ever in U.S. Armed Forces? 1. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Scheffel Olga Benner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reese Horne Husband 9113 East Stayman Drive; Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Crownsville VA Cemetery 1/4/2011 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 2122 M01052 MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ alic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of ; to from ediate Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 🔲 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of death? autopsy performed 2 No 2 **W**No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 A MG ဂ္ 1 Thipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: (Month, Day, Year) 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No. Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie D0061504 BEC, 30, 2010 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of persol 5755 Cedar du

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ THOMAS 18:35 M Sn DECEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LOCH PAVEN CLC BALTIMONE N/ASocial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Months Days Hours Min. MARYLAND Director 84 219-18-7539 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Tyes 2 No BALTIMORE N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 USA 2318 ASHBURTON ST Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: 3 x Widowed 4 □ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ie 1 and 2 should be filed within 72 t of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT SEAMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MARY LABERT JAMES HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2217 OREM AVE. BALTIMORE, MARYLAND 21217 MARSHER HARRIS (DAUGHTER) 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ R

4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1-10²2011 permit. Page 1 and Department of Hambortant: If its any injury or ot ation 3
Removal from State GARRISON FOREST VETERANS OWINGS MILLS, MARYLAND HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service D, 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ METASTATIC PROSTATE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PULMONARY OBSTRUCTIVE DISETISE Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗌 No 1 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Mursing Home 5 A Residence 6 Other (Specify) Hospital: 2 **N**o ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the I 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 28, 30272 sulle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 3900 LOCHRAVEN BOLILEVARD BALTIMONE, MARYLAND 2 1218 MILLEN. 31. Date filed (Month, Day, Year)

JAN 0 5 20 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Elizabeth Harrie 2010 Holmes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince 9. Birthplace (State or Areign egiona 16.8ex Hospita 8. Date of Birth Security Number 7. Age (In yrs. **Funeral** Dec. 24, 1923 Country) Virginia Min. 1 □ M 2 🖾 F Months Hours 223-82-6236 Director 86 Yrs Usual Residence of Deceden show 10b. County within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 X Yes 2 No VA Fauquier Warrenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 94-B Leeds Court 20186 IJSA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Black 1 Yes 2 No Specify If Yes, Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Domestic Private Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hoften 27 is marked of Item 27 is marked of rother traumatic ever ည Mason Carter Mittie Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6913 Riverdale Road, Lanham, Frenchy H. Segears -Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) First, Baptist Church Cemetery 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Page 1 Department of Important; If it any injury or o ō 12-31-10 The Plains, Virginia 21. Sign ture of Funeral Service Licen Joynes Funeral Home, Inc. 22. Name and Address of Facility PO Box 3633, Warrenton, Virginia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Ph sician/ rneumonia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Sepsis Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and burial-tran resulting in death) Last been signed by the attending physician should be detached for use as the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy performe prior to completion of cause of death? has after death.

Director: After this certificate 2 1 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License numbe D70093 ss of person who completed cause of death (Item 23a) (Type, Print) ·7300 Van Dusen Road, Laurel, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

05

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Holler 10:56 PM W Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 3 Yrs. Months Hours (Month, Day, **Director** Usual Residence of Decedent aith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show r traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director Kaltimore 1 XYes 2 □ No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working life DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ustodian Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname ည 19a. Informant's Name/Relationship (Type, Print er or Rural Route Harnes Department of Health Important: If item 27 any injury or other tronce. 20a. Method of Disposition Place of Disposition (Name of Date 1 X Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) 21. Signature of Funeral Service Licensee Maryland 21212 NO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cranaly Medical resulting in death) Due to (or as a conse dence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by tension duabetes, 1 ¥ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) Hospital 2 X No Other: 1 A Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Sulcide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical 29a. Certifier Example Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contifier 29c. License number 189105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Smith 03 Greene St gistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

		1- For State Registrar	Certi	ificate of Dea	th	Reg.	No.				
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last)	ent's Name (First, Middle, Last) 2. Date of Death Month Day Year December 25, 2010								
		4a. Facility Name (if not institution, give s St. Agnes Hospital	reet and number)		Town, or Location of Dea more	th	4c. County of Death	A			
Funeral Director		5. Social Security Number 6. Sex 118-58-9707 1 M	7. Age (In yrs. las	t birthday) If Und Mont	der 1 Year If Under 24H hs Days Hours M		MM/DD/YYYY) 9. Bird 22, 1975 Foreig Cor				
death with the Maryland or items 23a or 28a-f show any must be notified at once.	or	10a. State 10b. County	10c. City, To	Balti	nore			10d, Inside City Limits 1 Yes 2 No			
h the Mary 3a or 28a-	Director	33.19 Presst	mar S	+ 10f. Zi	21216		Citizen of What Cour	ntry?			
ter death wit ", or items 2	/ Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If	2. Was Decedent Ever in U.S. Armed Forces? Yes 2 No Yes, Give Year	If Yes, spec	ent of Hispanic Origin? (Specify Yes or No- to Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,			
36 in 72 hour han "natu	Completed by	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	Dates:	6a. Decedent's Usual	Occupation (Give kind or rking life. DO NOT use re		6b. Kind of Business/II	ndustry			
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than antic event, the Medica	Be	17. Father's Name (First, Middle, Last) Billy Davu	els	registra	18.Mother's Nan	ne (First, Middle, Main	den Surname)	riene			
re, MD 2121 s 1 and 2 should be fil f Health and Mental I If item 27 is marked	2[19a. Informant's Name/Relationship (Type AQVON Jones		19b. Mailing Address 3319 ace of Disposition (Na	Presstm	an St.	Balto	MD 21216			
		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Bathr	More, Ma							
_ ===.		21. Signature of Funeral Service Licensee	m Jell S	1. 4600	Address of Facility Liberty A	egnts A	The Both	1 House			
Physician Medical Examiner	8	failure. List only one cause on each Immediate Cause (Final disease a. Pu	^{ine.} Imonary Thromboembo	oli	or dying, such as pardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death			
	틸	Sequentially list conditions, b									
ecuted and - transit	Examine	(Disease or injury that initiated	to (or as a consequence of):								
icate be executed ficate be executed g physician and the burial - transi	Medical		MENDED 3c. If yes, outcome of pregnar	ncv			23d. Date of delivery				
	Clan	23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of death	2 Fetal death	3 Ectopic pregn			ay Year			
, P.O. E res that the d signed by the be detached	≥	Part II. Other significant conditions co	ntributing to death but not resu	Ilting in the underlying	cause given in Part I.		cco use contribute to t				
on of Vital Records, P.O. Box 68 ending Physician: The law requires that the death certificat. Or: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as	Completed					24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of			
Vital Rebysician: The this certificate I director, page	n i	25. Was case referred to medical examiner? 1 Yes 2 No	ital: 1 ✓ Inpatient 2 ☐ EF		26.Place of Death (Check		sidence 6 Other:				
ion of \tending Phylicath. tor: After the funeral	ation: 10	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury 28 FOUND: Pay, Year) F	OUND:	28c. Injury at Work? 1 Yes 2 No	28d. Describe how		s in 06/2010			
Division the Hospital or Attendin hin 24 hours after death, appletely filled in by the fil	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home (Specify) Single Family	/ Home		or Town, State Found, 3319 Pres	sstman St., Baltimo	re, MD			
To the Hospital within 24 hours To the Funeral completely filled	iğ	(Check only one) 2 Medical Examiner: On	To the best of my knowledge, the basis of examination and/of I manner stated.								
	ž :	29b. Signature and title of certifier August 46	elan	290	O.C.M.E.		ecember 26, 20				
	3	30. Name and address of person who com Carol Allan, MD Assistant	•	•	Baltimore, MD 2120)1					
Star Registra		31. Date filed (Month, Day, Year)	32. Pegistrar's Signature	-1	17.74 ta						

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 355 2010 AE JAMERSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SILVER SPRIN
If Under 1 Year If Under 24 Hrs. Cnoss MUNIGOMER 11014 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Year! Min. Days 1 □ M 2 🕅 F Months Hours 439-46-7233 Louisiana Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Eventine is ust be notified at 1XYes 2□No Director MONT MD SILVER SPRING 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20404 New HAMPShire USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 📉 No Specify: Specify: BLACK þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 nursing <u>healthcare</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dan Johnson Clotiel White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WAY. GERMANTUWN MD DAUTHTER KAMONA GORdy 1 RAilside 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Europa Strick Icensee Ropa Id. S. Wade, Director 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** N 20 KS /Medical Due to (or as a conseque ce of): Examiner WCOKS Se Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a d be detached for 1 □Yes 2 🗓 No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director, After this certificate has been si completely filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1) Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

SURESH

31. Date filed (Month, Day,

K.

Year)

Georgin

Ave

9801

MD

32. Registrar's Signature

Silver Soning MD 20402

10-10	062	2
David	Ο.	King

	1- For State Registrar	Cer	rtificate of Death		Reg. No.	
Physician/ Medical Examine	Decedent's Name (First, Middle,	_ast) O K	ing		Date of Death Month Day December 29, 20	
* 1	4a. Facility Name (if not institution, Johns Hopkins Hospita		4b. City, Town, Baltimore	or Location of Death	4c. C	ounty of Death
Funeral Director	216-08-2490	. Sex 7. Age (In yrs. la	NA CONTRACTOR	ys Hours Min.	March, 14,1	(YYYYY) 9. Birthplace (State or Foreign Country)
MOCE, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Fatath and Mental Hygeine. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Mar	fy Yes or No- 14 an, etc.)	Og. Citizen of What Country? 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: Race - Country Research			
11215-0036 Id be filed within 72 hours after forntal Hygiene. narked other than "natural", event, the Medical Examiner o Be Completed by	15 Decedent's Education (Specif	ced of Dates: y only highest grade completed) College (1-4 or 5+)	16a. Decedent's Usual Occup during most of working li	fe. DO NOT use retired	done 16b. Kind	d of Business/Industry
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the Medical To Be Compile	Derrick C). King	19b. Mailing Address (Str	Patri	rst, Middle, Maiden Su	Lee_
Baltimore, MD 2 permit Pages 1 and 2 shou Department of Feath and M Important: If item 27 is n injury or other traumaft	20a. Method of Disposition	3 Removal from State	13412 Lynd Place of Disposition (Name of or crematory or other place) Oun T ZION 22. Name and Addres 4400 LWB	1-3-	2011 MA	teral Hone
Physician Medical Examiner	23a. Part I. Enter the disease, or confailure. List only one cause of Immediate Cause (Final disease or condition resulting in death)		ds	g, such as cardiac or re	spiratory arrest, shock	or heart Approximate Interval Between Onset and Death
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	b. Due to (or as a consequence of Due to (or as a consequence of				
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteoding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Ex		d. AMENDED 5 per f 23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of de	nancy Fetal death	Ectopic pregnancy		Date of delivery onth Day Year
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as ledical Certification: To Be Completed by Physician	•		esulting in the underlying cause	e given in Part I.	1 Yes 2 N 24a. Was an autopsy performed?	e contribute to the cause of death? 10 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death?
i of Vital Recoing Physician: The law After this certificate has Suneral director, page 2 son; To Be Comp	examiner? 1 Yes 2 No		ER/Outpatient 3 DOA		lome 5 Residence	
Division of Hospital or Atteoding P 24 hours after death. Funeral Director: After stely filled in by the funer all Certification:		gation 28e. Place of Injury - At ho	0001 hrs 1	Yes 2 No Subuilding, etc. 28	or Town, State)	Number or Rural Route Number, City
Division To the Hospital or Attaolous within 24 hours after death To the Funeral Director: completely filled in by the		inned (Specify) Found on sisician: To the best of my knowledge iner: On the basis of examination and manner stated.	ge, death occurred at the time,	date and place, and du		nanner as stated.
P * F *	Theodor 70	t. King J.R., who completed cause of death (Nem	0.0	onse number C.M.E. OCM		te signed <i>(Month, Day,Year)</i> mber 29, 2010
State	Theodore M. King, Jr.,		Examiner 900 W. Balt	imore Street, Balt	imore, MD 21223	
Registra	JANU	- LUI Chrown	A. Marke			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar		Certific	ate of L	Death			F	Reg. No.			
Medic	Physicia al Exami	ın/	Decedent's Name (First, Middle 1)	Lori Kimble Month Day Year December 31, 2010							3. Time of Death 2325 hrs			
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Rosedale								4c. County Baltimo	re Cou	inty	
	Funeral Director		5. Social Security Number 218 – 68 – 9968	1 M 2 K F 54 Yrs.					er 24Hrs. s Min.	┥	0/1956	Foreig	thplace (State or in untry) PA	
	ryland a-f show any it once.	ctor	Usual Residence of Decedent 10a. State 10b. County MD Balt 10e. Street and Number	imore	0c. City, Town			seda	le		10g. Citizen of V	/hat Cour	10d. Inside City Limits 1 Yes 2 No	
)	th the Ma 23a or 28 potified a	I Director	11 Paula Pl					21237				USA		
	and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatte event, the Medical Examiner must be notified at once.	by Funeral	3 Widowed 4 X Div	orced If Yes, Give Year or Dates:	No No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No specify:					Whi Specify:	14. Race - American Indian, Black, White, etc. Specify: White		
036	ithin 72 hours ne. r than "natur fedical Exam	Completed	15. Decedent's Education (Specific Elementary/Secondary (0-12)	cify only highest grade compl College (1-4 or 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker						16b. Kind of Business/Industry Own Home		
21215-0036	uld be filed w Mental Hygie marked othe	Be Co	17. Father's Name (First, Middle, Benjamin	Cherry				M	Mari	an Bu				
MD 21	I and 2 should be f Health and Mental item 27 is marked r traumatic event,	٩	19a. Informant's Name/Relations Rose Marie U	nip(Type, Print) nitas / Sis	ster 1	b. Mailing A 0324	ddress (Stre Barbe	et and Num Pry	nber or R Lan	e, Fo	mber, City or To rt Myes	vn, State	FL 33913	
Baltimore, I	F. E. F.		4 Donation 5 Other Sp		Final	Place of Disposition (Name of cemetery, rematory or other place) nal Journey Crem. 1/5/2011					20c. Location - City or Town, State Woodbine, MD			
Balt	permit. Page Department Important: injury or otl		21. Signature of Funeral Service	ch. lous	holl	F		nd C 141	rema		Servic		1203	
1	nysician Medical xaminer		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	Drug I					0	xymorph	one	Approximate Interval Between Onset and Death	
		<u>•</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ										
	sd ssit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):								<u>-</u>	
_	icate be executed physician and the burial - transi	/Medical	X UNPENDED	d. AMENDED 23a 23	pt.II,	27,28 ne g91	a-f pe	r me	g913	3-10-	11 vt			
Box 68760,		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 🗸 Unk	23c. If yes, outcome 1 Live birth 4 Pregnant at tin	of pregnancy	Petal		Ectopic			23d. Date of Month	•	Day Year	
	hat the de ed by the etached fi	by Phy	Part II. Other significant conditi	o contraction	out not resulting	g in the und	erlying cause	given in Pa	art I.				the cause of death?	
Division of Vital Records, P.O.	the Hospital or Attending Physician: The law requires that the death certif hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending upletely filled in by the funeral director, page 2 should be detached for use as	Completed b	Multiple Sc	lerosis						24a. Was	an j 24b.	Were au	ably 4 Unknown topsy findings available completion of cause of	
Rec	cian: The l certificate l ector, page		25. Was case referred to medical				26 Place	e of Death	(Check o	1 🗸 Yes		✓ Ye	s 2 No	
Vita	hysician this cer al directe	10 Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatient		utpatient 3	DOA	Other4	Nursing	Home 5	<u> </u>		Scene	
on of	tending Ph eath. tor: After t		27. Manner of Death 1 Natural 5 Pend		r)	Time of Inju	1	ıryatWork Yes 2 🗶	1	28d. Describe	how injury occur	red		
Division	ospital or Attu hours after de ineral Directo y filled in by t	Certification:	3 Suicide 6 X Coul	290 Place of Injur		arm, street,		building, et	c.	or Town,	Street and Number 11 Pale, Md.		ral Route Number, City	
	To the Hos within 24 ho To the Fun completely	Medical ((Orrow only	hysician: To the best of my k										
	To To Com	₩	29b. Signature and title of certifie	and manner stated from			29c. Licens O.C.				29d. Date sign		nth, Day, Year)	
pond			30. Name and address of person Margarita Korell MD.	who completed cause of dea Assistant Medical E.		900 W. E	Baltimore S	treet, Ba	altimore	e, MD 2122	23			
V -	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	backs							-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month 9:40 Leander Ам 2010 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4210 Bar Harbor Place Prince George's 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) 1 M 2-311-84-3495 85 Director Guyana April 1925 Usual Residence of Decedent 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director or 28a-f s notified 1 Yes 2 No Prince George's Bowie 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? d Mental Hygiene. marked other than "natural", or items 23a or matic event, the Medical Examiner must be Funeral 4210 Bar Harbor Place 20720 USA permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event. The Medical Evaminar man 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. Completed 3 Divorced 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Leander Elizabeth Mary Cosbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Goodluck (Niece) 4210 Bar Harbor Place, Bowie, MD20720 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springfield Cemetery 01-4-2011 Springfield Gdns, NY 21. Signature of Funeral Service Licensee Name and Address of Facility Dy L. Gilmore Funeral Home 21-02 Linden Rd., St. Albans, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Cardiac Arrest disease or condition resulting in death) due to atherosclerosis Medical Due to (or as a consequence of) Examiner 204ecrs Coronery avtery Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hypertension 1 Tes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes 24a. Was an page 2 autopsy perchilescerdenic Yes 2 25. Was case referred to medical examiner?
1 Yes 2 No nin 24 hours after death.

the Funeral Director: After this certific npleted filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: ျာ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar

29b. Signature and title of certifier

M

Year,

nd address of person who completed cause of death (Item 23a) (Type, Print)

Morr

14300

Registrar's Signature

29d. Date signed (Month, Day, Year)

MI

D42719

Gallam Fox Lane "18 Bowie MD 20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 27, 2010 Thi Le December Giau 1:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) Sept. 9, 1953 9. Birthplace (State or Foreign Country)
Vietnam 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) Days 1 M 2 X F Hours Director 180-78-5237 Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No York York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 663 Chestnut Street 17403 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 🔯 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic e Le Van Sang Nguyen Thi Huan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 663 Chestnut St., York, PA 17403 Xuoi Truong (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Red Lion Cemetery 12/30/10 York, PA 21. Signature of Funeral Service Livenie 22. Name and Address of Facility Olewiler & Heffner Funeral Chapel & Crematory 35 Gotham Pl., Red Lion, PA 17356 men 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5SIS Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsequence of Exami The law requires that the death certificate be executed signed by the attending physician and doe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Year Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 Ho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No Yes 2 -To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 1No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO 00000100 12-27-10 TALtmins 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 Alfon Con 851

State Registrar 31. Date filed (Month, Pe

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 30,2010 Chien Song Lin 7:31 Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In vrs. last birthday) Funeral (Month, Dav. Year) Months Days Hours 1 12 M 2 1 F 135-98-1858 60 Taiwan 08/04/1950 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County or 28a-f shov 10c. City, Town or Location 10a. State the Medical Examiner must be notified at Director Linthicum Heights ¥☐ Yes 2 ☐ No Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21090 350 Schulamar Road Funeral items 23a death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 X Married "natural", or 2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Retail Sales Representative 18. Mother's Name (First, Middle, Maiden Surname) Yu Sha Wu Be 17. Father's Name (First, Middle, Last) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic and once. Fu Ren Lin 19a. Informant's Name/Relationship (Type, Print) Weiling Lin / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 350 Schulamar Road, Linthicum Hts., MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place, Final Journey Crem. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Woodbine, MD 1/4/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Pnysician Septic Should Medical resulting in death) Due to (or as a consequence of) Examiner · many Securities list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine as the burial-transit MURITATIO Due to (or as a consequence of) attending physician for use as the burial or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 L ed by the a 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 Yes Yes 2 certificate 26. Place of Death (Check only one) 25. Was case referred to medica funeral director, æ examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျ this Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: After t Natural Accident 5 Pending death. Investigation within 24 hours after death

To the Funeral Director: A
completed filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [only one) 29d. Date signed (Month, Day, Year) 29c. License number 29h Signature and title of certifie det D.O and address of person who completed cause of death (Item 23a) (Type, Print) 600 Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan K. Lowe 08:03 AM 12 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours 11/16/1943 215-40-2957 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director Baltimore Catonsville 1 Yes 2X No 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 303 Waveland Road 21228 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or ρ 1x Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Divorced 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Mechanic Metal Fabrication Be permit. Page 1 and 2 should be filed Department of Health and Mental Hyy Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry K. Lowe Thelma R. Kotschenreuther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Waveland Road, Catonsville, Maryland 21228 Mrs. Bonnie L. Lowe (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 01/03/2011 4 Donation 5 Other (Specify) Woodlawn, Maryland 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) aortic value insufficiency 24 hs Medical Due to (or as a consequence of): Examiner valve endocardit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed -eely Serratia bacteremia that initiated events resulting in death) Last Physician/Medical infected left hnee Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 Yes 2 No 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) AT 2438946-A7 12/28/2010 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 Leanne Foster East University Baitimore, MD Parlinay 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar X DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month PM Physician 101 2010 Recomber /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital Date of Birth (Month, Day, Year) 7/21/1917 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1 XM 2 □ F 93 Hours 301-03-6308 OH Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mind because once. 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b County Ellicott City 1 □XYes 2 □ No MD Howard Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 21043 3004 North Ridge Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 [If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🛣 No White Specify Specify چ ₩Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) State of Ohio Dir. of Laboratory 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eunice Miller Thomas J. Murphy ဂ္ 19a. Informant's Name/Relationship (Type. Print)

Thomas Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8152 Southwest Ashford Street, Tigard OR 97224 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12/23/10 Holy CRoss Cemetery Pataskala OH 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 E. Fort Ave, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DAWIL disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dule to (or as a contesquence of) or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day be detached for in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à **I** nknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? after death.

Director: After this certificate has page 2 No Yes 2 1 Yes 26. Place of Death (Check only one) completely filled in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Pesidence 1 🗌 Yes 25 No 2 ER/Outpatient 3 🗆 DOA 6 Other (Specify) Inpatient မ 27. Marrier of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Data of Injury 28b. Time of Certification: 5 Pending investigation (Month, Day Year) Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 4 Homicide 24 hours e Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Di Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20,2010 Recomber

State Registrar 30. Name and address of person who complete

31. Date filed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

d cause of death (Item 23a) (Type, Print)

32. Registra la Signature

11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 McNamara 10:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Villa Assumpta Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Feb. 24, Year 1 □ M 2 🗐 F Hours New York 217-54-9860 **Director** 88 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Stevenson Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21153 1531 Greenspring Valley Rd. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give ģ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sullivan Catherine Thomas McNamara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1531 Greenspring Valley Rd. Stevenson, Md. 21153 Patricia Hoeflich 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Sisters of Notre Dame 1-5-11 Ellicott City, Md. 4 ☐ Conation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Fineral Service Licen 1050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) 4 wee Medical **Examiner** S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe After this certificate has restencion 2 No 1 Yes 25. Was case referred to medical the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined within 24 hours a To the Funeral D Priffying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Could find Number Exaction on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Could find Number Exaction on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Could find Number Exact in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Could find Number Exact in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Could find Number Exact in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Could find Number Exact in the basis of examination and occurred at the time, date and place, and the cause (s) and remained at the time, date and place in the cause (s) and remained at the time, date and place in the cause (s) and remained at th (Chec 29b. Sigr 29d. Date signed (Month, Day, Year, -2011 30. Name wite 312 Towson State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh g911 1-5-11 vt
State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 255AM AR Medical 4a. Facility Name (if not institu in, give street and number) **Examiner** Hamilton 4b. City, Town, or Location of Death 4c. County of Death Center 8. Date of Birth (Month, Day, 9 Birthplace (State or Foreign Country) If Under 1 Year Funeral 7. Age (In yrs. last birthday) If Under 24 Hrs. 1 □ M 2 X F Days Months Hours Min 84 Yrs. **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 'natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 5 Other (Specify) 4 Donation 22. Name and Address of Folility 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of ch line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to completed filled in by the funeral director, page 2. 1 ☐ Yes ∠ ∠ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗭 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? >Natural 5 Pending injury 2 No Investigation 6 Could not be Accident Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUB 69 MACOL 31. Date filed (Month, Day, Year) 32. Registrar's Signature Stat Registrar DHMH 17 Flav 7/2009

State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Month Physician/ William S. Miller 12 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ALTIMORE SAMARITAN HOSPITAL GOOD 9. Birthplace (State or Foreign Country) unk 5. Social Security Numberunk 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral (Month, Day, Min. 1 🕅 M 2 🗆 F MRN 999979735 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director Towson Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ò USA Funeral 21286 items 23a 120 W. Pennsylvania Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. unk should be filed within 72 hours after of and Mental Hygiene. is marked other than "natural", or i ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) unk W アニア Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk ဂ္ဂ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5601 Loch Raven Blvd Baltimore, MD Good Samaritan Hospital VILLIAM Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ₩ Other (Specify) in state 21. Signature of Suneral Straice dicensee EtarcendAffaconfyciliBoard 655 W. Baltimore Street Mirector 21201 Baltimore, MD 23a, Part 1\ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician ENCEPHALOPATHY ANOXIC Medical resulting in death) Due to (or as a consequence of Examiner ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 Yes 2 L 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown HYPERTENSION . Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed' 1 ☐ Yes 2 ☐ No this certificate 2 🔀 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗷 No Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral (Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

17:31

10d. Inside City Limits

white

Approximate Interval Between Onset and Death

Day

Year

1 ☐ Yes 2 No

unk.

unk

State Registrar SUNGRYONG

DCH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOH

5601

RES - 000

RAVEN BIVD, BALTIMORE, MARYLAND,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eleanor L. Marine Month рм 2010 Medical December 6:52 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 6807 Fordcrest Road Baltimore Baltimore **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 190-40-8884 1 🗆 M 2 🕱 F Months Days Hours 04<u>/01/1950</u> Director 60 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified MD Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Fordcrest Road 6807 21237 Funeral USA death 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married <u>Ş</u> within 72 hours after ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours aft nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", If Yes, Give 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White Completed Specify: Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Character Interpreter Museum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Mullen Chaterine A. Jardot 19a. Informant's Name/Relationship (Type, Print)
Richard S. Marine / Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6807 Fordcrest Road, Baltimore, MD 21237 20a. Method of Disposition permit. Page 1 a Department of h 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State cemetery, crematory or other place) Important: If any injury or 4 Donation 5 Other (Specify) Final Journey Crem. 1/3/2011 Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service L Porota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Dur to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of, cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury signed by the attending physician and deetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Day Pregnant at time of death Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been : 24b. Were autopsy findings available prior to completion of cause of 24a, Was an 124 hours after death.
 Euneral Director: After this certificate has autopsy 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ြု 1 Tyes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Accident 1 \sum Yes 2 🗌 No Investigation i ☐ Suicide ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I one tifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sig nature 000 Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UState of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	rtificate of Death	Reg. No).			
Physici ∼dical Exami	an/	1. Decedent's Name (First, Middle,Last)	Mauger	2. Date of Death Month Day December 31,	3. Time of Death			
		Facility Name (if not institution, give street and number) Fort Washington Medical Center	4b. City, Town, or Location of Dea Fort Washington		c. County of Death Prince George's			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 12 M 2 F 4 5		/ /	M/DD/YYYY) 9. Birthplace (State or 1 9 6 5 Foreign MD Country)			
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City MD unkn.	r, Town or Location		10d. Inside City Limits unkn. 1 Yes 2 No			
death with the Maryland or items 23a or 28a-f show any must be notified at once,	Director	10e. Street and Number	10f. Zip Code	ınkn.	itizen of What Country?			
eath with the items 23a o	Funeral D	11. Marital Status 12. Was Decedent Ever in U 1 X Never Married 2 Married Armed Forces?		Specify Yes or No-	14. Race - American Indian, Błack, White, etc.			
rs after death ural", or iten	by Fu	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind o	work done 16b.	Specify: White Kind of Business/Industry			
Baltimore, MD 21215-0036 pernit. Pages and 2 should be filed within 72 hours after Department of Fel and Addited Hygiener In Titlem 71 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 4	during most of working life. DO NOT use re Painter		Self Employed			
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Cor	17. Father's Name (First, Middle, Last) David John Mauger	Toni	ne (First, Middle, Maider Kay				
MD 21 Id 2 should Ulth and Me m 27 is ma	To	19a. Informant's Name/Relationship (Type, Print) Toni K. Mauger / Mother	19b. Mailing Address (Street and Number or 30 Morningmist Di	rive, Fre	dericksburg YA 224406			
Baltimore, permit. Pages I an Department of Hea Important: If ite		1 Burial 2 K Cremation 3 Removal from State F1		5/2011 W	. Location - City or Town, State Joodbine, MD			
Balti permit. Departu Import injury		21. Signature of Funeral Service Licensee Dorota Marsh	V I PO BOX 1413	. Baltimo	ore, MD 21203			
Physician /Medical Examiner		Intillediate Cade (Final disease	nd cocaine intoxication		nock, or heart Approximate Interval Between Onset and Death			
	-	or condition resulting in death) Due to (or as a consequence of): b. Due to (or as a consequence of): b. Due to (or as a consequence of):						
ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
760, cate be executed physician and he burial - transit	dical		-f per ME G911 1/11/11					
Box 68760, ne death certificate be the attending physicine for use as the buri	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal death 3 Ectopic pregr		3d. Date of delivery Month Day Year			
o ± 8	by Phys	Ja Jinkiowii	resulting in the underlying cause given in Part I.		acco use contribute to the cause of death?			
rds, require been si hould b	Completed		i ga marin	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of			
Division of Vital Records, sa der detections and Attending Physician: The law requirements and price and the this certificate has been seled in by the funeral director, page 2 should it.	Be Com	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	26 Place of Death (Check	Yes 2 1	No 1 Yes 2 No			
Physic rr this	2	1 ✓ Yes 2 No	ER/Outpatient 3 DOA Other Nurs 28b. Time of Injury 28c. Injury at Work?	ing Home 5 Resid	dence 6 Other:			
Sion O tteoding death. ctor: Afte y the fune	Certification:	1 Natural 5 Pending fd.12/31/10	fd.2:56am 1 Yes 2 X No	unk.				
Divisital or /	ertifi	Suicide Could not be	iome, farm, street, factory, office building, etc. in van	or Town State)	and Number or Rural Route Number, City rich Dr. Accokeek, MD			
Division of Vital Reco To the Hospital or Atteoding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination a and manner stated.		nd due to the cause(s) a				
H % H 8	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		Date signed (Month, Day, Year) nuary 1, 2011			
		30. Name and address of person who completed cause of death (Item Jack Titus MD. Deputy Chief Medical Examine		e, MD 21223				
S	tate							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:20 Geoffrey W. Moore December [2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth Months 1**X** M 2 □ F Days Hours 09/18/1974 Michigan 218-17-5340 Yrs. Director 36 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified MD N/A Baltimore 1 X Yes 2 No ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ral", or items 23a Examiner must b 21212 905 East Lake Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married 1 Yes If Yes, Give 2**X** No Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental မ George W. Moore Barbara L. Struble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 East Lake Avenue, Baltimore, Maryland 21212 Mrs. Barbara L. Moore (Mother) permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 01/06/2011 Trinity Cemetery Baltimore, Maryland Donation 5 Other (Specify) Signature of Funeral Service (Cense 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗖 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 04 Phi State 5

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 4:20 A Dorothy Estella Martin Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 315 Bowleys Quarter Rd. Middle River Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Davs Hours Country)
Maryland **Director** 213-28-0254 80 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 315 Bowleys Quarter Rd. 21220 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Edward Bratt Estella Elizabeth Kendall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Cucina / Daughter 8017 Horicon Pnt. Dr. Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 4, m. 2011 1 🕅 Burial 2 🗆 Cremation 3 🗔 Removal from State 4 Donation 5 Other St Crownsville MD Vet. Cém. Crownsville, Maryland 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P. 421 Crain Hwy. SE; Glen Burnie, Signature of Funéra 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Cancer Physician/ Metas tatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Dire to for as a consequence of signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Dav 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 X No certificate has 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5X Residence 6 \square Other (Specify) Hospital မ 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending iniury X Natural Accident
Suicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Ched only Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certifier 29b. Signat 29d. Date signed (Month, Day, Year) 32 Donuary Name and address of person who completed cause of death (Item 23a) (Type, Print)
140 Min (M.D.) 9114 Philadelphia Road #208, Baltimore, MDZ1Z37 Registrar's Signatur 31. Date filed (Month, Day, Year) State 5 0 Registrar

David Naida

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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	1- For State Certificate of Death Reg. No.									
Physician/ Medical Examine	1. Decedent's Name (Fi	irst, Middle,Last) Naida					2. Date of Death Month December	Month Day Year December 21, 2010 1827		
	4a. Facility Name (if not Rt.50 & Castle	et institution, give street and n Marina Road	umber)		City, Town, or Lo Chester	ocation of Deat	h	4c. County of Queen A		
Funeral Director	5. Social Security Numb		7. Age (In yrs. last birt 44	thday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Mir		9. Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)PA		
Aaryland 28s-f show any 1 at once. ector	PA L	o. County Jackawanna	10c. City, Town	or Location		ranton			10d. Inside City Limits 1 X Yes 2 No	
the Maryland 3a or 28a-f sh otified at once	10e. Street and Number	Bryn Mawr St	reet		Of. Zip Code	8504	10	og. Citizen of What Country? USA		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3 VVIdowed	2 Married Armed F 1 X Yes 4 Divorced If Yes, Give Ye or Dates:	2 No	If Yes	specify Cuban, I	Mexican, Puerto		14. Race - American Indian, Black, White, etc. Specify: White		
5-0036 ed within 72 hours tygiene. other than "natus the Medical Exam		ation (Specify only highest gra ary (0-12) College (de completed) 16a. 1	during mos	Usual Occupation of working life. Cl Lawn Ser	OO NOT use re		16b. Kind of Bus Lands	caping	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	17. Father's Name (Firs Robert A		a		18		e (First, Middle, M ol Sepk			
shou and N	19a. Informant's Name/I	•	Mother	1216	Bryn Ma	awr, Sci	canton P	A 18504		
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 Injury or other traus	4 Donation 5	Cremation 3 X Removal f	rom State Cathe	ory or other dral	Cemetery	7 1	Date 2/27/10	Scranto		
	0,00	al Service Licensee VICLO		15	<u>Ul East</u>	FORT AV	<u>renue, Ba</u>	<u>ittimore</u>	MD 21230	
Physician Wedical Examiner		one cause on each line. al disease a. Multiple In		or enter the	mode or dying, so	as cardiac	or respiratory arre	st, shook, of fredi	Between Onset and Death	
iner	Sequentially list condition if any, leading to immediate cause. Enter Underlyin	diate Due to (or as a	a consequence of):							
cuted und transit al Examiner	(Disease or injury that is events resulting in deat		a consequence of):							
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial: transitedical Certification: To Be Completed by Physician/Medical Ex	UNPENDED IF FEMALE: 23b. Was decedent preg past 12 months?	gnant in the 1 Live		Fetal		Ectopic pregn	ancy	23d. Date of d Month	elivery Day Year	
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f Vital Physician: or this certifical director, To Be (examiner?	No Hospital: 1	Inpatient 2 ER/0	utpatient :	DOA O	ther Nursi	ng Home 5 F	Residence 6	Other: Scene	
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Division of a Hospital or Attending Phewithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Holing and Certification: Teddical Certification: T	3 Suicide 6 4 Homicide	Could not be 28e. Place	e of Injury - At home, fa Major Road / Hi		factory, office bui	lding, etc.	or Town, St		or Rural Route Number, City Chester, MD	
To the How within 24 h To the Full completely	one) 2 Med	rtifying Physician: To the be dical Examiner: On the basis and manner:	of examination and/or in		, in my opinion, o	death occurred		nd place, and du	e to the cause(s)	
	29b. Signature and title	DZ.			29c. License r			December 2	1 (Month, Day, Year)	
	30. Name and address of Ana Rubio MD.	of person who completed cau . Assistant Medical		Penn Str	eet, Baltimore	e, MD 2120	1			
State Registra	31. Date filed (Month Dev., Name 32. Registrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 4664 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Nea Physician/ 4:20 M james 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Care Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9 Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Director 79 10-14-1931 218-26-0357 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 10a. State filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director XXYes 2 No MD BALTIMORE TURNER STATION 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 626 NEW PITTSBURG AVENUE 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. Minit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examina once. 1 ☐ Yes 2 ☐**X**No If Yes, Give þ 1 Never Married 2 Married timore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed BLACK Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ENTERTAINMENT 10 BARTENDER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ AGNES_BLAND JAMES E. NEAL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MILDRED HEGGINS/SISTER <u>626 NEW PITTSBURG AVE. BALTIMORE, MD 21222</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HOLLY HILL MEM. GRDNS .: MIDDLE RIVER, MD 1-6-2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. Sime 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Dementa disease or condition Medical resulting in death) Due to (or as a consequence of) Disorder Examiner elusiona Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine bue to for as a consequence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Sclerosis 24b. Were autopsy findings available prior to completion of cause of death? Multiple 24a. Was an autopsy has Heart Failure stive To the hy wall or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page Conge 1 Yes 2 No Yes 2 No 25. Was case regred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 5 \square Pending 1 🔀 Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number Hopkins Bayview Circle Balt Baltimore MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 ntuia a 31. Date filed (Month, Day, Year)

JAN 0 5 2. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/) Month 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ealth 8. Date of Birth Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Hours 1 □ M 2 🛛 F a Director Yrs. Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural". or items 23a or 28a.t ehm 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ျ 19a. Informant's Name/Relationship (Type, Print Step Ghter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) Joseph L. and Address of Facility 21. Signature f uneral Service Licens Home 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician/ EMBOLISM ULMONARY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury Examine Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by CANCER 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at s after death. injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 00061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3250 WILLERS AVE #307 BALT. ESENEZER QUAMPOO ms 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

ORIGINAL

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enita Pinkney		State of Maryland / Department of 1-For State Certificate of Registrar		/giene Reg. N	2010	1866
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, Last) Benito Pinkney 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Date of Death Month Da December 24	y Year , 2010 4c. County of Death	3. Time of Death 1253 hrs
Funeral Director		Nothwest Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 199-54-3025 1 M 2 F Yrs.	Randallstown If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (M	Baltimore Cour IM/DD/YYYY) 9. Birth Foreign Cour	place (State or
tth the Maryland 23a or 28a-f show any notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati MD Baltimore Owing: 10e. Street and Number	S Mills 10f. Zip Code 21117	10g. (Citizen of What Count	10d. Inside City Limits 1 Yes 2 No
r death w or items	ed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced of Yes, Give Year 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedend during market	is Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto F Yes 2 2 LNo specify: It's Usual Occupation (Give kind of woost of working life. DO NOT use retire	ork done 16	14. Race - America White, etc. Specify: B	ack
21215-0036 uld be filed within 72 Mental Hygiene. marked other than " c event, the Medical I	e Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) The state is Name (First, Middle, Last) UNK	ice Technic	(First, Middle, Maid		unication
를 많 하는	To Be	Arthory Price 504 20a, Method of Disposition 20b. Place of Disposi	Address (Street and Number or Ro E Madison ition (Name of cemetery,	Ave, K	City or Town, State, ACCN CI	2, NJ08049
Baltimore, permit. Pages la Department of He Important: If its		1 Burial 2 Cremation 3 Removal from State crematory or oth 4 Donation 5 Other Specify. 21. Significare of Funeral Service Licurisee	Family Cen 1-8	3-2011 well	Callano	ls, VA
Physician Wedical Examiner	2 2	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence.of):	00 10000	respiratory arrest, s	SOCITO .	Approximate Interval Between Onset and Death
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):				
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ords, P.O. E w requires that the c s been signed by the should be detached	Ď	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	1 Yes 2		bly 4 Unknown
Vital Recolysician: The law his certificate has director, page 2 sh	Be Completed	25. Was case referred to medical examiner? Hospital: 1 Innation 2 FR/Outpatient	26.Place of Death (Check of		death? No 1 Yes	mpletion of cause of
Division of Vital Records, P.O. rai or Attending Physician: The law requires that the stater death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	욘	The state of the		Home 5 Resi	injury occurred	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	al Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, stree (Specify) 28e. Clace of Injury - At home, farm, stree (Specify)		or Town, State)		
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier All Dav	29c. License number O.C.M.E.	29	place, and due to the d. Date signed (Monto	h, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 21201			
St Regist	ate rar	31. Date filed (Month, Day Mean) 2011 32 Registrar's Signature	W			

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per INF G918 8/08/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sex Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 272/1917 190-07-9862 1**XX**M 2 □ F 93 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must he matitud at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 Saddle Ridge Road 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify: 3 Midowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired). Customer Service Technician 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Natural Gas Co. 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Giovanni Paola Maria Sacco-Paola 19a. Informant's Name/Relationship (Type, Print)
John Paola / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Saddle Ridge Rd, Annapolis MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Mt. Royal Cemetery 1 Burial 2 Cremation 3 Removal from State 1/3/11 Shaler Township, PA 4 ☐ Donation 5 ☐ Other (Specify) charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue, Baltimore MD 21. Signature of Funeral Service Licensee Victor P. Doda 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical Examiner resulting in death) D Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 1 🗌 Yes 2 X(Vo ER/Outpatient 3 DOA |은 1 Inpatient 2 I Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work As after decorated Director: Affilled in by the 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nature and title of co 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OU Medical 4a. Facility Name (if not institution give street and number, **Examiner** City, Town, or Location of Death 4c. County of Death 8. Date of Birth Birthplace (State or Foreign **Funeral** Hours Min (Month, Director Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 □ No treet and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementan Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Maiden Surname ၉ Rural Route Number, City or Town, State, Zip, Code) Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Signature of Funcil Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyl such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) SIE IAN Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death been signed by the 9 Unknown a 🗆 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy 2 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2**)** No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \quad Yes Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Natural injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ted cause of death (Item 23a) (Type, Print) 31 Date filed (Month egistrar's Signat State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month INGRID 3:48 а м PIERRE - LOUIS DECEMBER 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 1950 Daninica.Commonwealth Director 217-23-7753 60 Jan. Usual Residence of Decedent 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No MD Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral items 23a 968 Fairmount Avenue 21204 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc should be filed within 72 hours after ò 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: 21215-003 If Yes, Give Year or Dates 3 Widowed 4 Divorced ^{Specify:}West Indian S 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Computer Programming Information Technology Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Garford Pierre-Louis Ionie Lewis Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerlyn Thomas 968 Fairmount Avenue; Towson, / daughter MD 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Pleasant Rest Cem. 1/6/2011 Towson, MD 21. Signature of Fu 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cap that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death HYPOXIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ARREST ARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last OVARIAN CANCER Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [호 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy l director, page death? 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ 1 Yes 2 X No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) MO 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DWSON 31. Date filed (Month, Day, Year) State Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

JAN 05

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at ORGE.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar 1. Decedent's Name (First, Middle, La	eetl					-	2. Date of De	aath			3. Time of	Dogui
					Month			Year	7:35			
Larry L. Proff:		.)		4h. City. To	wn, or Location	of Death	Decemi			of Death	1.33	AIT
Future Care Sa		,			timore				, .			
		ge (In yrs. last I	birthday)	If Under 1	Year If Unde	r 24 Hrs.	8. Date of Bi	rth .		9. Birthp	lace (State o	r Fore
461-18-7252 Usual Residence of Decedent	1 ∑ M 2□F	99	Yrs.	Months E	Days Hours	Min.	May 17	, 191	1	Coun	ntry)	un
10a. State 10b. County		10c. City, To	own or Loc	cation		-				11	0d. Inside C	ty Lim
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10e. Street and Number			alti	10f. Zip Co	ode			10g. Citiz	en of W	/hat Coun	ntry?	
1000 N. Gilmore				21217				US	SA			
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1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	l ^{No} un	ık	1 Yes, specify 1 ☐ Yes 2—7			Hican, etc.)		Black Specify:	k, White, wh	etc. nite	
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(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or	5+)	life. E	DO NOT use i	done during mo retired)	ist of work	ing					
unk u	ınk											
17. Father's Name (First, Middle, Last	9			unk	18. Moti	ner's Nam	e (First, Middle	, Maiden S	Sumame	Θ)		unl
19a. Informant's Name/Relationship ((Type, Print)	10	9b. Mailin	ng Address (S	treet and Numi	ber or Run	al Route Numb	er, City or	Town, S	State, Zip	Code)	
Future Care Sandt	own	1	1000	n C1	Imoro C	+*****	Dalad		157	010	117	
0a. Method of Disposition			of Dispos	sition (Name natory or othe		tree	Date	20c. L c	ation - (City or To	wn, State	
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Speci		•	1017, 01011	matory or our	ii piace)							
		.e										
			22	. Name and A	Address of Faci	lity			_			
21. Signature of Funeral Service Lice Ronald S		ector	St	ate An	atomy 1	Board		. Balt	timo	re S	treet	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RAIND Physician/ Month / 2 0500 M OU (S Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mandrin Hospice House Harwood Arunde l Anne Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min Hours New York Director 048-20-5263 82 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f shor Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Calvert 1 X Yes 2 No Prince Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 115 Allnutt Court 20678 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Mason Construction Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Louis Praino Mary Rinaldi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Praino / Son 125 Walton Road, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State ō Department o Important: If any injury or Anatomy Gifts Registry 01/03/2011 4 X Donation 5 ☐ Other (Specify) Hanover, Maryland 21. Signature of Fundal Service Icen ee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** S squentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death n signed by the a Id be detached f 1 Yes 2 L 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an the Funeral Director: After this certificate has mpleted filled in by the funeral director, page 2.3 performe 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 100 Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA DICE 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred HUGSE work? 1 Yes 2 No 5 Pending injury Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifie 29c. License number Name and address of person ho completed ause of death (Item 23a) (Type, Print) CHAB 31. Date filed (Month, Day, Year) Registra s Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ December рΜ 2010 8:15 Anthony J. Rivetti, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Frederick Villa Nursing Center Catonsville 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex Funeral Days April 30,1918 1 🛛 M 2 🗆 F Months Hours Min. Pennsylvania 92 **Director** 168-10-8854 Usual Residence of Deceden 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State should be filed within 72 hours after death with the Maryland Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified 1 🗌 Yes 2 🖾 No Baltimore Catonsville <u>Maryland</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21228 2314 Rockwell Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Year or Dates. 1942-45 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City nd Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Schools Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ည t. Page 1 and 2 should be trument of Health and Mentartant; If item 27 is marked ijury or other traumatic e Rosa Tortora Louie Rivetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2314 Rockwell Avenue; Catonsville, MD 21228 Wife Margaret P. Rivetti Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State Crestlawn Mem. Garden 12/31/2010 Marriottsville, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Sign u re of uneral Service Do Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Se Immediate Cause (Final Physician/ 0515 disease or condition resulting in death) Medical Due to (as a consequence of): Examiner 120 Sequentially list conditions, if any leads of cause. Enter Underlying Cause (Disease or iinjury Examiner Due to or as a consuluence of ementia that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Season at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 →No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requires Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 038762 28/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Sharm Mc Cornack

faith well, Mar 2129 31. Date filed (Month, Day, Year) 32. Pedistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year Edna Rosetta Shaffer : 450 Medical 32 0 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5155 Bonnie Branch Road Ellicott City Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 9, 1933 **Funeral** 9. Birthplace (State or Foreign 1 M 2 XF Months Hours **Director** Maryland 216-28-5081 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Howard Ellicott City 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5155 Bonnie Branch Road 21043 USA "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White 3 Divorced 4 Divorced Specify traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than "any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer Wilson Edna Knickman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5155 Bonnie Branch Road; Ellicott City, MD 21043 Thomas Shaffer Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Atlantic Crematory 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Glen Burnie, MD 4 Donation 5 Other (Specify) 1/4/2011 Sterling Ashton Schwab Witzke Signal re of Fineral Service Lice. 22. Name and Address of Facility Sterling Ashton Sc Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Jementic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): been signed by the attending physician Physician/Medical The law requires that the death certificate be Box 68760 use as IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Unknown Month Dav Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performe within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Certificate: To Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deevak Beskero 1.1kg 31. Date filed (Month A State Registrar

1218 HG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 December 2:00 P M Nicholas Louis Sikalis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1910 Victory Drive Halethorpe 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 26, **Funeral** Year) 1942 1 X M 2 □ F Months Days Hours Director 212-38-4736 68 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is involved. Every the must be notified at once. 1 ☐Yes 2 ☐No Director MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 USA 1910 Victory Drive Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ≥ Specify: white 3 ☐ Widowed 4 🏋 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas L. Sikalis Sr Millison Marie Hayes ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1910 Victory Drive Halethorpe, MD Denise Fiorini/fiancee 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5駅Other*(Specify)* in state 21. Signable of Fundal Service Licensee Konald S. Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a confequence of): **Physician** 54rs disease or condition resulting in death) /Medical Examiner pertension Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed Smoker attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. ed by the a ☐Yes 2☐No 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performe certificate 1 □Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) and manner stated 29b. Sigrature and title of certifier 29d. Date signed (Month, Day, Year) December 26,2010

State Registrar 2009 DRUID HILL BREJIMORE, MD 21217

me and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

SERRY BENSON HUNT, MO

Day, Year)

VOID

CERTIFICATE

2010-41876

SEE

CERTIFICATE #

2011-00358

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Month **Physician** Year 140 QM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner are Lanor Baltimore Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/29/1947 9. Birthplace (State or Foreign **Funeral** 62 Months Days Hours Min 1 □ M 2 12 F **Director** Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, If a Medical Examinar must be notlined at Director 1 X Yes 2 ☐ No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6600 Ridge Road Funeral 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔯 No Specify þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If item 27 is marked other the any Injury or other traumatic event, Italians. Waitress Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas C. Thatcher Mary Lee Spies 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel Deal / Daughter 402 Scarsdale Road, Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatany Gifts Registry 01/03/2011 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician multiple disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner woll Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) burial-Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year Day 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed' 1 ☐ Yes 2 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within ? 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) It fonte 308 BALTIMORE MI) 21201 2110. LASHM) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ 2010 1:52 P M ames Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE BON SECOURS HOSPITAL 5. Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □_XM 2 □ F 56 243-94-5075 SOUTH CAROLINA Director -6 - 1954Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Medical Examiner must be notified at Director 1 XYes 2 No BALTIMORE N/A MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Funeral items 23a USA 21216 2306 WINCHESTER APT B 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ö 1 Never Married 2 Married ş Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: BLACK "natural", 3 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) than College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha STOFFER FURNITURE MOVER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ ALBERTHA JACKSON BUSTER SHAW permit. Page 1 and 2 should be Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2306 WINCHESTER APT B BALTIMORE, MARYLAND SHAW (WIFE) VANESSA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other pMETRO CREMATORY 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State injury or BALTIMORE, MARYLAND 12-31-2010 5 Other (Specify) 4 Donation uneral Service L HIBNER^{22. Name and Address of Facilit}PHILLIPS FUNERAL HOME, P.A. 21. Signature of any 1721-27 N. MONROE ST. BALTIMORE. 23a. Par/1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or ruspiratory arrest shick, gi heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but pet resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Onknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy death? this certificate 1 🗌 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner2 Hospital 1 __Inpatient 2 _ ER/Outpatient 3 -မှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? 1 Natural 5 Pending _____ vatural

Accident 2 🗆 No 24 hours after death. Funeral Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check within 2 3 □ only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dealhonne stree 31. Date filed (Month, Day, Year) 🔊 32. Registrar State JAN 05

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Physician/ Louis F. Schmidt 2010 3:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4411 Woodlea Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 1 🔀 M 2 🗆 F Months Hours Min. 1172371923 87 Maryland Director 216-16-9847 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4411 Woodlea Avenue 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced White "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 0 Fleet Managei Trucking marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Frank Schmidt Unknown Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health ar Important: If item 27 is Irene H. Schmidt / Wife 4411 Woodlea Avenue, Baltimore, Maryland 21206 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 1/4/2011 Baltimore, Maryland Scrutur of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition one year Medical resulting in death) Due to (or as a consequence of): Examiner TYPERTENSION VS Sequentially list conditions, Examine if any, leading to immediate cause. E. ter Underlying Cause (Disease or iinjury Due to (or as a consequence of): STUEROSCI EROSIS that initiated events Due to (or as a consequence of) resulting in death) Last burial physician Physician/Medical that the death certificate be EMENTIA Box 68760 the attending ph I for use as tl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Year signed by the a q ☐ Unknown g Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy this certificate Yes 2 L the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manuar of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28b. Time of : After t 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ww D22 652 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21239 BALTIMORE LOCARAVEN BLYD. DYS. SRINIVAS 5601 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State barker Registrar 1AN 05

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month Agathe Johanna von Trapp Dec. 28 5:20 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson <u>Baltimore</u> 8. Date of Birth (Month, Day, Mar, 12, 1 7. Age (In yrs. last birthday) **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Days 1 ☐ M 2 🕱 F Hours Director 127-14-1138 97 1913 Austria Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2331 Old Court Road, #107 21208 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: marked other than "natural", 3 Widowed 4 Divorced White Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT user etired)
MUSICIAN, Author, Artist 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Lz should be filed within 7 th and Mental Hygiene. 77 is marked Att Elementary/Seconday (0-12) College (1-4 or 5+) 12 Education Kindergarten Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Georg Johannes von Trapp Agathe Whitehead von Trapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Mary Louise Kane-Daughter Old Court Road, #107, Baltimore, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
yon Trapp
Family Cemetery 1 🔀 Burlal 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) 5,2011 Jun Signature of Funeral Service Licensee White-Fiess Funeral Home 22. Name and Address of Facility PO Box 838, Morrisville, Vermont Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Opcet and Death Immediate Cause (Final Physician/ disease or condition resulting in death) COREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Month Day Pregnant at time of death signed by the a d be detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTONSION Records, 1 Yes 2 No 3 Probably 4 Unknown Completed ATRIAL FIBRILLATION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy CONGOSTIVE HEART FAILUPE death? Hospital or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 | No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending n 24 hours after death.

e Funeral Director: After selection of the function o Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier сотретер Medical Examiner: Of the basis of examination who will be called a Certifying Nurse Practioner: To the best of my knowledge, death or 3 urred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of contifie December 29 2010 and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Alexis Williams State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day December 30, 2010 Medical Examiner 0400 hrs ALEXIS WILLIAMS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital **Baltimore** N/A 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Foreign 219-90-0705 1 X M 2 F 45 8-6-1965 Country) MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "antural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. MD. N/A1 Yes 2 No BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3502 COTTAGE AVE 21215 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? X Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Yes 3 Widowed 4 Divorced f Yes, Give Year 1 Yes 2 No specify: Specify: ~ BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CLERK GROCERY STORE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) ROBERT HARDY LILLIAN HARCUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LILLIAN HARCUM(MOTHER) 3502 COTTAGE AVE. BALTIMORE MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Buriay crematory or other place) remation 3 Removal from State 4 Domation 5 Other Specify KING MEMORIAL PARK 1-6-2011 BALTIMORE. HIBN R Name and Address of Facility REDD FUNERAL SERVICE JON THAN D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Approximate Interval ailure. List only one cause on each line Between Onset and /Medical Asthma Death ediate Cause (Final disease Examiner condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical the attending physician and for use as the burial -X UNPENDED] AMENDED 23a,pt.II,27 per me g912 2-9-11 vt Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Atherosclerotic Cardiovascular Disease 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy certificate has prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other this 1 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural 5 Pending Director: 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) filled within 24 hours a

To the Funeral 1 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 30, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State 3 Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:15 A M William Carson Wiley, Sr. December 3: Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium 7. Age (In yrs. last birthday) **85** Yrs. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Dave Hours Min, 4/2/1925y, Year) Country) Mary land 1 XM 2 🗆 F Director 192-16-8033 Usual Residence of Decedent Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Mary land Howard Marriottsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1310 Cedarberry Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give should be filed within 72 hours after 1 ☐ Yes 2 No Specify: 3 ★ Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sales Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Franklin Wilev <u>Margaret Connable</u> Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Bradshaw / Daughter permit. Page 1 and 2 1310 Cedarberry Court Marriottsville, Maryland 21104 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗗 Cremation 3 ☐ Removal from State 1/3/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 22. Name and Address of Facility Ruck Towson Funeral Home. Inc. Signature of Euneral Service Licenses 111 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final sthenia Mya Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death. **To the Funeral Director**: After this certificate has I autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural injury 2 🗌 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) her 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

2010

December

Wiley

William

Justine Prei

31. Date filed (Month, Day, Year)

JAN 0 5 20

2300

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene 16b, 20a, -c, 22 per fn, g918, 98/10/2011dhb
Registrar Certificate of Death Reg. No Registrar 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0732 AM James Edward Wilkins Decembr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Min. 1 ፟ M 2 ☐ F Month Day, Year) ine 26, 1941 Hours Maryland 219-38-3793 Director 69 June Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ò Funeral 23a 21209 USA 2700 N. Charles Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò 1X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: black permit, Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Indust (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk laborer Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Cook Florence Wilkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Fullard - niece 719 Cliff Edge Road; Baltimore, Maryland 21208 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 3 State (Specify) 11 State Western Star Cemetery 01/10/2011 Catonsville, MD Signature of Euneral Service Licenses Resterstown Rd., Baltimore, MD 21215 ector 23a. Part 1. Enter the dil ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shirts, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Physician/ disease or condition resulting in death) Medical Due to or as a consequence of Examiner months provas Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam The law requires that the death certificate be executed attending physician and for use as the bunial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav signed by the a d be detached f Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 🗌 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA ٥ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of eartifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neon MMI W 31. Date filed (Month, Day, Year)

Year

DHMH 17 Rev 7/2009

State Registrar

10-10018	
Robert Williams	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert Williams		1- For State	tate of Maryla		oartment c e <i>rtificate o</i>		id Menta	l Hygiene	Reg. No.	2010	41884
Physicia	_	Registrar 1. Decedent's Name (First, Midd	lle,Last)					2. Date of D Month	eath	Year	3. Time of Death
Medical Exami		Robert William	ns					Decemb	per 27, 2		1410 hrs
		4a. Facility Name (if not institute	on, give street and nu	ımber)		4b. City, Town, o Baltimore	r Location of D	eath	4c.	County of Deat	h
F		St. Agnes Hospital 5. Social Security Number	6. Sex	7 Age (In vrs	s. last birthday)	If Under 1 Yea	ar If Under 2	4Hrs. 8 Date of	Birth (MM/I	n/a	rthplace (State or
Funeral Director		218-40-0820	71	Yr	Months Day		Min.	1/1939	Forei		
	ŀ	Usual Residence of Decedent	1X M 2 F	/ 1	***	s		4/14	1/ 1935	,	,,
Any	ı	10a. State 10b. County		10c. Ci	ty, Town or Loca	ition					10d. Inside City Limits
Maryland 28a-f show 1 at once.	5	MD n	/a	В	altimore	9					1 X Yes 2 No
Maryl	Director	10e. Street and Number				10f. Zip Code			_	en of What Cou	intry?
0036 within 72 hours after death with the Maryland gione. rer than "astural", or items 23a or 28a-f sho Medical Examiner must be notified at once.		2803 Washingto					1230		US		day to the Disab
tems	Funeral	11. Marital Status 1 Never Married 2 N			lf '	as Decedent of Hi Yes, specify Cuba			No-	White, etc.	rican Indian, Black,
P 9 8			1 Yes vorced If Yes, Give Yes	2 X No ar	1	Yes 2 X No	specify:			Specify:	White
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	ē Š	15. Decedent's Education (Spe	or Dates:			nt's Usual Occupa	ation (Give kind		16b. K	ind of Business	
72 ho	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	- during r	nost of working life	e. DO NOTus	e retired)			
Media	Completed	10)	D:	isabled	4014	lame (First, Middl		Disable	ed
다 B 등 등 점		17. Father's Name (First, Middle Wallace C. Wil						ed L. Ho	The state of		
2121 ald be fi Mental J marked	To Be	19a. Informant's Name/Relation			19b. Mailir	ng Address (Stre					a, Zip Code)
		Ronald Willia	ms / Broth	ner	8238	Bernard	d Drive	South,	Mille	ersville	e, MD 21108
Ore, MD ges 1 and 2 sh tof Health an Hitem 27 i	1	20a. Method of Disposition	0 D D 16		b. Place of Dispo crematory or o	sition (Name of ce	emetery,	Date	20c. L	ocation - City or	r Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 X Burial 2 Crematio 1 Donation 5 Other S		I	•	ark Ceme	tery	1/4/2011	Ba	ltimore	, Maryland
Baltimo permit. Page Department of Important: injury or ott	V	1. Ignature of Funeral Service			22.	Name and Addres	s of Facility	Hubbard	Funei	cal Home	e, Inc.
	_	23a. Part I. Enter the disease, o									land 21229 Approximate Interval
Physician /Medical		failure. List only one cause	e on each line.				i, such as card	lac or respiratory	arrest, silo	ck, or near	Between Onset and Death
Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a			sease					Deali
		Sequentially list conditions,	b	2 001,004201100							
	je	if any, leading to immediate	Due to (or as a	a consequence	e of):						
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence	e of):						
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iO, to be executed ysician and burial - transit	edical	UNPENDED	AMENDED								
Box 68760, e death certificate be the attending physical for use as the burned for use a	₹ Me	IF FEMALE: 23b. Was decedent pregnant in t		outcome of projects		etal death 3	Ectopic pr	egnancy		f. Date of deliver Month	ry Day Year
OX 6876(eath certificate attending phys	Physician/M	past 12 months?	4 Pregr	nant at time of	dooth -	other (Specify)		ognanoy			,
BOy e death the att	hys		9 Unkn								
that the d ned by the detached	by P	Part II. Other significant condi	tions contributing to	o death but no	t resulting in the	underlying cause	given in Part I				the cause of death?
S 50 5	E G				<u> </u>						utopsy findings available
cords, aw requir has been s	Completed							au	topsy rformed?		completion of cause of
Vital Rec ysician: The his certificate director, page	S						(5 1) (6)	1 ✓ Ye	s 2 No	1 🗸 Y	es 2 No
ital Reician: The secretificate rector, pa	Be	25. Was case referred to medica examiner?	The section is	Inpatient 2	✓ ER/Outpatier		e of Death (Ch	ursing Home 5	Reside	nce 6 Othe	er:
n of Vision Physics After this funeral dir	P	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of		ury at Work?			iry occurred	
OD C	틸		iding	n, Day,Year)		1	Yes 2 No	·			
VISION Atta	lica		estigation 28e. Plac	ce of Injury - At	t home, farm, str	eet, factory, office	building, etc.		n (Street a	nd Number or R	ural Route Number, City
Divis Hospital or A 24 hours after Runcral Directely filled in b	Certification:	4 Homicide	ermined (Specify)					OI TOWN	i, State)		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Physician: To the beaminer: On the basis								
Di To the Hospital within 24 hours a To the Funeral completely filled	Medical	one) 2 ✓ Medical Example 29b. Signature and title of certifications	and manners		i and/or investig		se number	, sa ac are une, u		Date signed (Mo	
		M .					.M.E.			ember 28, 2	
		30. Name and address of perso	n who completed cau	se of death /Ite	em 23a)						
		Donna M. Vincenti, M		Medical Ex		1 Penn Stree	t, Baltimore	e, MD 21201			
St	ate	31. Date filed (Month, Day, Year,		egistrar's Sign	ature	, ,					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 23 2010 GAZELDA RENEE' WILLIAMS 0725 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6319 Seat Pleasant Drive Prince George's Capitol Heights 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Min. 1 □ M 2 🖵 F 09-05-1968 **Director** 213-08-7735 42 Usual Residence of Decedent or 28a-f shown notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Prince George' Capitol Heights ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 6319 Seat Pleasant Drive 20743 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Specify: Black Completed 3 Widowed 4 N Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Federal Gov't Analyst Be it. Page 1 and 2 should be filed rtment of Health and Mental Hy rtant: If item 27 is marked oth njury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Clayton Herring Paula Ann Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 Tiera Herring/Daughter 6319 Seat Pleasant Dr., Capitol Heights, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Cedar Hill Cem. 4 Donation 5 Other (Specify) 01-03-2010 Suitland, Maryland 21. Signatur Funeral Service Licenses 22. Name and Address of Facility PA Cedar Hill FH,4111 Ave. 3a. PaN1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Atherosclerotic CARTICVASCULON Hea Onset and Death Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No å 25. Was case referred to medical 26. Place of Death (Check only one) examiner2 Hospital: Other: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Qcetifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 2010 30 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar 300,

HUS 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Edna Grace Abel 1:35 December 16, 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Homewood at Crumland Farms If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 7, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 X F 91 1919 New Jersey 158-03-6748 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County a or 28a-f show t be notified at 28a-f show 1 ☐ Yes 2 X No Maryland Frederick Frederick Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21702 7407 Willow Road "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Elliot Abel Jennie Patterson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 0.D: 12 16 permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau 10243 Rolling Ridge Ct., Myersville, MD 21773 Margaret Eisenhower / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 17. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Crematory 2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Restnaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** avaironyopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Abel Due to (or as a consequence of) Examiner that initiated events resulting in death) Last and Due to (or as a consequence of) Edna attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year ō in the past 12 months? Month Day SSS 5 ☐ Other (specify) ☐Yes 2 No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pnysicians 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Was a autopsy performed 2 No 24a. Was an certificate 1□ Yes Vita 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Tyes 20 No 1 🗌 Inpatient Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 2 Or in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Director: After (Month, Day Year) To the Hospital or Attending within 24 hours after death. 5 ☐ Pending investigation Known to 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12-17-10 CIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 2170) 650 4 Shah Thomas 31. Date filed (Month, Day, Year) 32. Registrat's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

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			StateRegistrar				Cer	tifica	te of L	Death		Reg. N	0.			
	Physicia Medic		1. Decedent's Name Mary		Ruth	Al	dridg	е			2. Date of De Month Decemb	er 2	23, 201	ar LO	3. Time of 1:00	
	Examin	er	4a. Facility Name (if I	not institution, give bot Stree						Location of Death erland	1	4	c. County of D Alle	eath egan	У	
	Funeral Director		5. Social Security Nu 220-40-14	92 1	x	e (In yrs. last 68	birthday) Yrs.	If Und Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Da 01/31/	ay, Year)		Birthplac Country)		Foreign
	aryland la-f show ified at	ector	Usual Residence of 10a. State MD	Decedent 10b. County Allega	iny	10c. City,	Town or Loc	eation mber	land					10d.	Inside Cit	•
	with the IVs 23a or 28	Funeral Director	10e. Street and Num 508 Ta	_{ber} lbot Stre	et			10f. Z	ip Code	21502		10g. C	itizen of What	Country	?	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	ed by Fun	11. Marital Status 1 ☐ Never Marrie 3 🏋 Widowed 4		12. Was Decedent I Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates.		l II	Yes, spe	ecify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		14. Race - A Black, W Specify:	hite, etc.		
21215-0036	thin 72 hour ne. than "natu ne Medical	Completed by	Elementary/Seco	15. Decedent's Edify only highest granday (0-12)			life. DO	kind of w O NOT u	ork done o se retired)	ation during most of wor	king		Kind of Busine		try	
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	nd 2 should salth and N n 27 is ma er traumai		19a. Informant's Na Victoria	1 , ,	rpe, Print) e / Daught					and Number or Ru enue, Cui					le)	
Baltimore,	Page 1 arment of He tant: If iter				Removal from State	cen		natory or nd C	other place remat	ory 12/2		Cı	ocation - City	nd,	MD	
Balt	permit. Depart Import any inj		21. Signature of Fun	eral Service Licens	and					ss of FacilityAda Ir Street				215		.A.
	Physician/ Medical		23a. Part 1. Sater the shock, or hear Immediate Cause (Fidisease or condition resulting in death)	t failure. List only of inal	olications that caused the cause on each line a. <u>Arteri</u>	<u>oscle</u>	rotic				or respiratory a	rrest,		In	pproximate terval Betv nset and D	ween
-	Examiner	er		nditions,	b. Due to (or as											
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092	aath certificate be executed attending physician and for use as the burial-transit	ledical		·	d											
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 🖸 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal c	leath 3 🗀	Ectopic Other (pregnanc specify)	су			23d. Date of Month	delivery Da	ay Y	⁄ear
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Recor	Physician: The law rec r this certificate has bee aral director, page 2 sho	Complet									24a. Was auto perf 1 🗌 Yes		prior death	to comp	findings a letion of ca	vailable ause of
ital	ician: certific rector,	Be	25. Was case referre examiner? 1 X Yes 2	-	Hospital:				Oth	ace of Death (Che						
ν of V	ing Phys	ate: To	27. Manner of Death 1 X Natural 2 Accident	5 Pending	28a. Date of inju (Month, Da	ry 28 ry, Year)	R/Outpatien Bb. Time of injury		28c. Injury	4 ∟ Nursing F y at	lome 5 X Res 28d. Describe			oecify)		
Division of Vital Records,	al or Attences after death	Medical Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined			e, farm, stre	M eet, facto		res 2 🗆 No	28f. Location (City or To			Rural Ro	oute Numb	er,
_	the Hospit nin 24 hour the Funera	Medica	(Check 2 only one) 3	Medical Exami Certifying Nurs	sician: To the best of ner: On the basis of e se Practioner: To the	xamination a	nd/or invest	igation, ii leath occ	n my opinie urred at th	on, death occurred e time, date and pla	at the time, date	and plac ne cause	e, and due to t (s) and manner	he cause as state	d.	nner stated.
	With To With To To To To To To To To To To To To To		29b. Signature and t	itle of certifier	Ih	,		29	Jc. Licenso	number D09157		29d. D De	ate signed (Mo cember	23,	/, Year) 2010)
	2068		30. Name and addre Paul	ss of person who co	D., 124 W	. Thir	d Str	reet	, Cun	berland,	MD 21	502				
	Sta Registr		31. Date Wed Month	, Day, Year) 2010	32. Registra	ar's Signatur	e avel	,								

Examiner law requires that the death certificate be executed burialattending physician for use as the buria Division of Vital Records, P.O. Box 68760 ed by t s been signed be should be detr

page 2 s

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To the Hospital of within 24 hours a To the Funeral D completed filled in

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Certificate:

Medical

27.

Hospital or Attending Physician: The

Physician/

Medical

Examiner

Funeral

Director

3a or 28a-f show the notified at

ral", or items 23a Examiner must be

27 is marked other than "natural", traumatic event, the Medical Exal

or other

should be filed within 72 h and Mental Hygiene.
7 is marked other than "r

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permit. Page 1 a Department of H Important: If ite any injury or ott

Physician/

Medical

Examiner

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown Completed by

Accident

Suicide

4 Homicide

25.1

Was case referred to medical examiner?		2	26. Place of Death (Chec	ck only one)
1 E Yes 2 PNo	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other: 4 \(\sum \) Nursing H	ome 5 🗆 Re
Manner of Death Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)		Injury at work?	28d. Describe

e how injury occurred work? 1 ☐ Yes 2 ☐ No Investigation

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nume Practioner: To the best of my knowledge, death continue at the time, date and class and due to the cause(s) and manner as stated. (Check

29b. Signature and title of certifier

29c. License number D0065024 29d. Date signed (Month, Day, Year) 12/27/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONIQUE 50 M H

251 E. Antietam St., Hagerstown, MD

21740

State Registrar

03H-12

31. Date filed (Month, Day, Year) **DEC 2** 8 **201**0 32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DE<u>CEMBER</u> Ellen Albright 2010 Medical 4:55A.M 4a. Facility Name (if not institution, give street and number)
Reeder's Memorial Home **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Boonsboro Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** Hours 1007277/1932 Director 234 46 8381 78 West Virginia Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Washington Boonsboro Yes 2 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 21713 141 S. Main Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, 1 Never Married 2 Married white Completed by Yes 2XXIIo 1 Yes 2 No Specify: If Yes. Give "natural" 3 XWidowed 4 Divorced Specify. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 212 Elementary/Seconday (0-12) College (1-4 or 5+) 12 administration factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h permit. Page 1 and 2 should be file Department of Health and Mental timportant: If item 27 is marked o any injury or other traumatic eve once. Hugh S. Ronk Margaret F. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Brant/daughter 120 Hidden Acres Rd. Inwood, WV 25428 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 🖾 🖔 urial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Rosedale Cemetery 12/24/10 Martinsburg, 21. Signature of Funeral Service Lice 22. Name and Address of Facility Rosedale Funeral Rd. Martinsburg, Home WV 25404 917 Cemetery 23a. Part 1. Enter the disease, or complications mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition year Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Exami resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy director, page 2 should be detached for in the past 12 months? 5 Other (specify) Month Day Year Yes 2 No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) ဂ္ဂ 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and til

JH-5 State

AM

Registrar

DHMH 17 Rev 7/2009

20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAFAR MALIK,

144996

29d. Date signed (Month, Day, Year)

301-432-8470

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ! Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 24, 2010 Physician 2:02 Gladys Arnold P.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Homewood at Williamsport Washington Williamsport Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 30, 1906 9. Birthplace (State or Foreign Country) Maryland Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 1 □ M 2 💢 F 104 232-62-9400 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 🏋 No Director Washington MD Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 United States 16505 Virginia Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Public Schools Pages 1 and 2 should be filed inent of Health and Mental Hyginnt; If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jessie B. Arnold Henry U. Harrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health as Important; If item 27 is any Injury or other trau 925 Turin Street, Rome, NY 13440 Anne Vittorello--Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 12/27/2010 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 95 Union Street 2541 Helsley-Johnson Funeral Home. Berkeley Springs, WV M00522 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cans Approximate Interval Between Onset and Death that caused the death elon each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) 16 H /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician I for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Voluming Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Tes 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signate 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and add

O DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day

32. Regis

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 Day Margaret Holland Brown 2010 Tear 18 4:09 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3900 South Mountain Road Frederick Knoxville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Days Hours Min 49747474923 Director 87 220-18-0134 Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick 1 Yes 2X No MD Knoxville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3900 South Mountain Road 21758 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. <u>\$</u> 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 🏋 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Beautician Beauty Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Department of Health and 2 should be Department of Health and Menta Important if item 27 is marked any injury or other traumationone. ည Ridgley Holland Grace Giles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Bush, Daughter 3900 South Mountain Road, Knoxville MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State St. Marys Cemetery 12/23/2010 4 ☐ Donation 5 ☐ Other (Specify) Petersville MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bustane A Williams John T Williams Funeral Home, Brunswick MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ 20,00 Cancer with disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been sinned by the attendion abundant man physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as t the attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month 1 Yes 2 2 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy death? perforn Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 28d. Describe how injury occurred 1. Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D09689 POFVR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUSTIN PEARE FREDERICK MD 300 W. NINTH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month December 10, 2010 Year Erma Gay Bonser 11:10 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Allegany 4b. City, Town, or Location of Death **Examiner** Frostburg Village Nursing Care Center Frostburg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) November 10, 1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Min. 1 M 2 K 86 417-28-0089 Mississippi Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Jry or other traumatic event, The Medical Evanmar must be notified as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Frostburg Maryland Director 1XYes 2 No 10e. Street and Number 17512 Cains Circle, S.W. 10f. Zip Code 10g. Citizen of What Country? 21532 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 No Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 0 College (1-4or 5+) Elementary/Secondary (0-12) Court Reporter U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry H. Bailey Nettie Rogers ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlie Bonser 21532-17521 Cains Circle, S.W. Frostburg Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State **Cumberland Crematory** Cumberland December 13, 2010 Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. neral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of

To the Funeral Direct

completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 00055325 mount

Registrar
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Bishop

32. Registrar's Signature

10-09449 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Krystal Diamond Brown State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day December 8, 2010 **Medical Examiner** 1829 hrs KRYSTAL DIAMOND BROWN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5 Social Security Number 7 Age (In vrs. (ast birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Foreign ASHINGTON Hours Min Director 1 M 2 X F Yrs 219-98-2099 3/20/1982 Usual Residence of Decedent 10d. Inside City Limits III 10c. City, Town or Location 1 X Yes 2 No s 23a or 28a-f show e notified at once. 28a-f show hours after death with the Maryland Maryland Prince George's Capitol Heights 10g, Citizen of What Country? 10e. Street and Number ö 6842 Walker Mill Road # 301 20743 USA 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Armed Forces? White etc. 2 X No Yes 9 If Yes, Give Year 3 Widowed 4 Divorced Yes 2 No specify: Specify: BI RACIAL 5 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 hent of Health and Mental Hygiene. **Baltimore, MD 21215-0036** 12 UNEMPLOYED PRIVATE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) UNKNOWN NORMARICE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMARICE BROWN LOFTIS/ MOTHER <u>6842 WALKER MILL</u> 301 CAPITOL HEIGHTS,MD 20743 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State 12/16/10 Donation 5 Other Specify: RIVERDALE PARK RIVERDLAE, MARYLAND 22. Name and Address of Facility nature of Funeral Service Licensee POPE FUNERAL HOMES, P.A. MOLOSS 5538 MARLBORO PIKE FORESTVILLE, MARYLAND 20747 Flart I. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical attending physician or use as the burial UNPENDED AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 V Unknown for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ፩ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available autonsv prior to completion of cause of has performed? death? page 1 ✔ Yes 2 No After this certificate 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Division of Vital Other Nursing Home 5 Residence 6 Other DOA 1 Yes 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Subject pedestrian struck Dec 8, 2010 1 Natural 1738 hrs - death. 5 Pending 1 Yes 2 ✔ No the 2 🗸 Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) WB Walker Mill Rd and Silver Hill Rd, Capitol Heights, M (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. S To the 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe O.C.M.E. December 9, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature. State DEC'2"2010

DHMH 17 Rev 1/2001 **OCME 2006**

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12/12/201 CLEVELAND BOYETTE 5:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5917 Center Drive Temple Hills Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□ M 2 □ F Months Days Hou*rs* Min. Director 246**-**46**-**4481 Fremont. N.C. Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director YX Yes 2 No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5917 Center Drive 20748 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 XYes 2 No Black, White, etc. Completed by 1 Never Married 2 Amarried 1 XYes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. 3 Divorced 4 Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insulator <u>Private</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Cleveland Lewis Alma Bovette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline Boyette / Wife Center Drive Temple Hills, Maryland 20748 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Speqify) 12/28/2010 Maryland Veterans Cheltenham, Maryland 21. Sign Jure of Funeral Service Lic 22. Name and Address of Facility Pope Funeral Homes, P.A. 010108 5538 Marlboro Pike Forestville, Maryland 20747 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ MYELOID LEUKEMIA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2X N certificate 2 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Other: ပ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tes 2 🗌 No Accident Investigation within 24 hours after death To the Funeral Director: completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif

State Registrar 9200 BASIL COURT SUITE 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IVAN ZAMA

31. Date filed (Month, Day, Year,

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LARGO, MARYLAND 20774

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 12/16/201 Joseph Webster Bentley Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House Rockville Montgomery If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Hours Min **Director** 06/19/1925 228-24-0584 Alexandria, VA 85 Usual Residence of Decedent 28a-f shov 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 ☐ No Silver Spring MD Montgomery 9 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral # 3154 Gracefield Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian event, the Medical Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 X Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 5+ <u> Electrical Engineer - NASA</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ Raymond Asa Bentley <u> Lillian Elizabeth Neal</u> 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaina Bentley McFarlane 6516 Westview Lane Lanham, MD 20706 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 12/22/2010 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Signature of Funeral Service Licensee 20722 Montgoney 3401 Bladensburg Road Brentwood, MD estam 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death signed by the a Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Cardiomyopathy page 2 should been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an CHF has autopsy perform death? this certificate History of MI Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🎦 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 🗷 Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work? 5 Pendina 1 Yes 2 🔲 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner To the best of my 29b. Signature and tife 29d. Date signed (Month. Day, Year) 0

State Registrar Road

20850

Rockville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muncaster Mill

6001

Debrah Miller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBERDAZI 2010 9:00 A BOGER SALLIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death
PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💁 Days Min OCT 22 579-64-8720 66 VIRGINIA 1944 **Director** Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No MD PRINCE GEORGE'S CAPITOL HEIGHTS 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6812 WALKER MILL ROAD #101 20743 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 Married 1 Yes 3 Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Specify: "natural" 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12TH DOMESTIC PRIVATE marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JAMES WILKINS LUCILLE HAWKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 2140 ADELINA ROAD CLINTON, MARYLAND 20678 item 27 MARIA TOLSON/SISTER injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 12/29/2010 SUITLAND, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 eath. Do not enter the mode of dying, puch as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that cause the shock, or heart failure. List only one cause on each list. Immediate Cause (Final Physician/ CU disease or condition Medical resulting in death) Due to (a consequence of **[√]Examiner** BSCLEROT MUIDVASC Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of iinjury that initiated even seculting in death). Due to for as a consequence of: transit and physician a Be Completed by Physician/Medical CERTIFICA P.O. Box 68760 as 1 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mo 1 Yes 2 for Month Day been signed by the should be detached 9 Unknown Part II. Other significant conditions contribution eath but not resulting in the underlying cause given in Part I. 23e. Did tobaced use contribute to the cause of death? a) con t Records, 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? unev 24a. Was an cate has perfo Ceno am or 2 🛣 No 1 🗌 Yes Yes Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ပ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. 5 Pending During central line placement 12/19/2010 Unknown M 1 ☐ Yes 2X No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Hospital** 28f. Location (Street and Number or Bural Route Number City or Town, State) **7503 Surratts** Rd., filled in by determined Clinton, Hospital 24 hours Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one MD

Registrar

DHMH 17 Rev 7/2009

State

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Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	Buas		Name and Addres			eral Home	20601	
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-	Physician/		shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition	1 1	131	adder	Canle	·		Interval Between Onset and Death	
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s		4 Homicide determined 28e. Place of Inj	jury - At home, f cc. (Specify)	farm, stre	et, factory, office	28	f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,	
	e Hospi 24 hou e Funer	Medical	29a. Certifier (Check Check only one) 3 Certifying Physician: To the best of the ideas of a control of the ideas of a cont	examination and/	or investi-	gation, in my opinio	n, death occurred at th	e time, date and	place, and due to the	cause(s) and manner stated.	
	No the within to the comp		29b. Signature and title of certifier	l. 0		29c. License			d. Date signed (Month		
			Popular Mull	M.V)	-		9478	D	ecember	12,200	
P	53621		30 Name and address of person who completed cause of c	D 5	LUype, Pr	arrett	Avenue	La fla	ita, MD	20641	
	Stat Registra		31. Date filed (Month) Day, Year) 32/Registr	ar's Signature	6.	W. 8					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9.54 am Ralph Ernest BLANKENSHIP Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1039 View Street Washington <u>Hagerstown</u> 8. Date of Birth (Month, Day, June 10 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Min. West Virginia 79 Director 236-46-3064 Usual Residence of Decedent or 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Washington Hagerstown 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1039 View Street 21742 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) n Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 ge 1 and 2 should b it of Health and Mer. If item 27 is marke James Cloyd Blankenship Corbie Cleo Trent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t Jane Blankenship - Wife 1039 View Street, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Hill Cemetery 12/29/10 Hagerstown, Maryland Signature of Funeral Service Licen 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final set and Deat Physician/ CANCER MUNTH LUND disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ner Due to (or as a consequence of) Examin sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No detached 9 Unknown g Unknown P.O. signed by the Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy Yes director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗖 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Frantianer To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner at stated. (Check 29b. Signature and title of certifie 29c. License number 29 Date signed (Month, Day, Year) ٥ eted cause of death (Item 23a) (Type, Print) 3H-6+1 Hagers r's Signature.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 2:58 December Medical David 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's 8. Date of Birth (Month, Day, Year)
April 30 1929 Virginia Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) If Linder 1 Year If Linder 24 Hrs. **Funeral** Days Min. Hours 1 XM 2 🗆 F Director 29-24-1718 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Md Prince George's Seat Pleasant 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 USA 7108 Fresno Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 XYes 2 NoARMY
If Yes, Give
Year or Dates. <u>۾</u> 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 all Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Construction Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ပ Unknown permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Lilly Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Ray Pannell/Son 2806 Marcia Place Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Md Veterans Cemetery 12/27/2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home, Inc. 21. Signature of Funeral Service Licenses 7474 Landover Road Hyattsville, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused to the book, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed' 1 ☐ Yes 2 🛣 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 \sum Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 2010 D63388 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) GRIFFIN DAVIS MO 2150 Pennsylvanie Avenue N.W. Washington, DC 20010 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $10 \quad 2010$ Physician/ DECEMBER MINERVA BUTLER 3:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Age (In yrs. last birthday) 1 🗆 M 2 🗆 🗓 Days JULY 7 Min. SOUTH CAROLINA 248-54-8883 Director 75 Jsual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1105 ROLLINS AVENUE 20743 USA 12. Was Decedent Ever in U.S. Arroed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc . or 1 Never Married 2 X Married Completed by BLACK 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6th DOMESTIC PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT WHITE MARYBELL SCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 ROLLINS AVENUE CAPITOL LEROY BUTLER/HUSBAND HEIGHTS MARYLAND 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State MD VETERANS CEMETERY: 12/27/2010 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 lewi-23a. Part 1. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ CARDIAC ARREST Medical Due to (or as a consequence of) Examiner END STAGE RENAL DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami SEVERE METABOLIC DERANGEMENT that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical DIALYSIS ending p use as 1 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Yea 5 Other (specify) Pregnant at time of death the a 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🙀 No ဂ္ 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident npleted filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and litle of co 29d, Date signed (Month, Day, Year)

State

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Yea

HAROLD V. LAWSON M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

tarks

D67589

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 16, 2010 Physician/ Emily 2:25 pmM Brooks Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs, last birthday) **Funeral** (Month, Day, B • 26, Min. Country) NEW YORK 1 □ M 2🗶 F 075-12-9625 Director EB. 88 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Martal Hyglene. In Department of Heath and Martal Hyglene in Internation of thems 23a or 28a-f s Important! It item 27 is marked other than "instural", or items 23a or 28a-f s any injurt; titem 27 is marked other than "instural", or other traumatic event, the Medical Examiner must be notified. MD. MONTGOMERY ROCKVILLE 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 VEIRS DRIVE Funeral 20850 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 2 XNo ☐ Yes 1 Yes 2 X No Specify: If Yes, Give Specify: BLACK 3X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JAMES WALLACE EDITH STAPLETON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CORA BROOKS-WHITE DAUGHTER 10213 DAPHNEY HOUSE WAY, ROCKVILLE, MD. 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🕅 Cremation 3 🗆 Removal from State METROPOLITAN CREM. 12/21/10 ALEXANDRIA, 4 Donation 5 Other (Specify) 22. Name and Address of Facility 2222 WISCONSIN AVE., NW 21. Signature of Funeral Service Lide illia HYSONG CO. WASHINGTON, DC 20007 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying shock, or heart failure. List only only callse on each tin. such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital Other: 1 🗌 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending nours after death. neral Director: Af I filled in by the fur 2 Accident
3 Suicide
4 Homicide 2 No 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 21726 Name and address of person who completed cause of death (Item 23a), (Type, Print) nw eirs 10 rather Karesh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Briodu 0410 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 00/ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, FEB 5 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. NEW JERSEY **Director** 110-26-7557 76 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No OCEAN PINES MARYLAND WORCESTER 10e. Street and Number 9 10f. Zip Code 10g, Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 Funeral 29 SLOOP LANE 21811 USA 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates, 1954-56 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) POLICE OFFICER LAW ENFORCEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ WALTER BRIODY **META** DUCHARDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARAH A. BRIODY/WIFE 29 SLOOP LANE, OCEAN PINES, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CREMATORY OF DELMARVA: 12/18/10 DELMAR, DELAWARE 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): If any, leading to immediate cause. Enter Underlying Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events -tran Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Year Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 🗌 Yes 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di Manner of Di ath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 🗌 Yes 2 🗆 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the b est of ny knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of cent Signature IVA me and address of person who completed ca 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Wayne Anthony Bucci State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.									
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Wayne Anthony		Bucci			2. Date of Dear Month December	th Day Year r 12, 2010	3. Time of Death 1242 hrs	
And the state of t	4a. Facility Name (if not institution, give street and not 2022 Gaither Street	ımber)	4	b. City, Town, or Lo Temple Hills	ocation of Deat	h	4c. County of Prince Ge		
Funeral Director	5. Social Security Number 6. Sex 579-86-7812 1XM 2_F	7. Age (in yrs. last 51	birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Min			9. Birthplace (State or Foreign Country) Washington, DC	
Maryland 28s-f show any 1 at ouce. ector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George	11	own or Location					10d. Inside City Limits 1 Yes 2 X No	
death with the Maryland or items 23s nr 28s-f sho must be notified at once. uneral Director	10e. Street and Number 2022 Gaither Street			10f. Zip Code 20748	3	10	0g. Citizen of What USA	Country?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 12 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "matural", or items 23a nr 28a-f sho injury or other traumatic evect, the Medical Examiner must be notified at once. To Be Complisted by Funeral Director	1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced 1 Yes, Give Yes	2 X X No	If Ye	Decedent of Hispa s, specify Cuban, N Yes 2 X No	Mexican, Puerto s <i>pecify:</i>	Rican, etc.)	- 14. Race - White, o	American Indian, Black, etc. White	
5-0036 led within 72 hours Hygiene Hygiene "matur the Medical Exem Completed I	15. Decedent's Education (Specify only highest grant Elementary/Secondary (0-12) College (12 years	I-4 or 5+)			O NOT use ret	ired)	D.C. Fi		
21215-(build be filed v Mental Hygi marked uth ic eveot, the	17. Father's Name (First, Middle, Last) Lawrence A. Bucci 19a. Informant's Name/Relationship (Type, Print)		AON MACE		Ph		A. Hinder City or Town.		
, MD 21 und 2 should ealth and Me em 27 is ma raumatic en	Pamela J. Bucci / Wife		2022	,	Street		Hills, M. 20c. Location - C	D 20748	
Baltimore, cernit. Pages I and pages I and pages I and pages I and pages II and pages II ultimate II liter in an ingrey or other tra	1 Burial 2 XX Cremation 3 Removal fr 4 Donation 5 Other Specify:	om State crer	matory or othe as Crei	natory	12	/17/2010	Edgewa	ter, Maryland	
	21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 23. Part I. Enter the disease, or complications that c	gueed the death. Do	010	JU UXUII II	TTT VA	. UXON H	ill, mar	eral Home P.A. yland 20745	
Physician /Medical Examiner	failure. List only one cause on each line.	ensive At						Between Onset and Death	
ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequence of):			-				
nted d ansit Examine r	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	consequence of):					<u>.</u>		
50, te be executed sysician and burial - transi	X UNPENDED AMENDED	23a,ptI,	IIperM	E,G911,1,	/14/201	1,WS#27	1 22d Date of do	livos	
certific	23b. Was decedent pregnant in the past 12 months?	irth ant at time of death	2 Feta	I death 3	Ectopic pregna	ancy	23d. Date of de Month	Day Year	
P.C es that gened by	Part II. Other significant conditions contributing to Chronic Alcohol Abuse	acco use contribute to the cause of death? 2 No 3 Probably 4 Unknown							
Division of Vital Records, P.O. Box at or Attending Physiciae. The law requires that the death as Director: After this certificate has been signed by the attending the fineral director, page 2 should be detached for are retificated in by the funeral director, page 2 should be detached for artification: To Be Completed by Physis						24a. Was a autops perform	sy prio med? dea	re autopsy findings available r to completion of cause of th? Yes 2 No	
Vital Rechysiciae: The this certificate I director, page	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 1	npatient 2 ER	NOutpatient		Death (Check		Residence 6	Other: Scene	
ion of tending Ph	27. Manner of Death 28a. Date	of Injury 28 Day,Yeer)	Bb. Time of Inju		at Work?	28d. Describe h	ow injury occurred		
- B = E - B - E - B - E - B - E - B - E - B - E - B - E - B - E - B - E - E	3 Suicide 6 Could not be determined (Specify)	e of Injury - At home	e, farm, street,	factory, office build	ding, etc.	28f. Location (So or Town, St		or Rural Route Number, City	
Fo the Ho within 24 P To the Fur completely	29a. Certifier 1 ☐ Certifying Physician: To the bes (Check only one) 2 ✓ Medical Examiner: On the basis of and manner st	of examination and/o		n, in my opinion, de	eath occurred a		ind place, and due	to the cause(s)	
	29b. Signature and title of certifier	\mathcal{L}		29c. License n			29d. Date signed December 13	(Month, Day, Year)	
	30. Name and address of person who completed ears Laron Locke MD. Assistant Medica	· ·	•	Street, Baltimo	re, MD 212	01			
State Registrar	31. Date filed Month, Gyrear 2011	gistrar's Signature	parke	/			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Boehme Kenneth Peter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Allegany** Western Maryland Health System Cumberland 8. Date of Birth (Month, Day Year) Aug - 2, 1961 Birthplace (State or Foreign Country)
 Germany If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 1 X M 2 🗆 F Hours Min. Director 49 223-11-5080 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 X No Springfield WV Hampshire 10e. Street and Number 10g. Citizen of What Country? Funeral 26763 HC-65 Box 2650 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Completed by 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur H. Boehme Erna Christine Deub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC-65 Box 2650 Springfield, WV 26763 (wife) Sharon Duke 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/20/10 Cresaptown, MD <u>Scarpelli F.H. PA</u> 21. Signature of Funeral Service License 22. Name and Address of Facility McKee Funeral Home 115 E. Birch Lane Romney, WV 26757 23a. Part 1. Enter the disease, or complications that or used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Acute endocarditis 3 day Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Multiorgan failure Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 🔽 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 **X**Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0059987 12-18-10 morio 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland, MD 21502 Christopher Vagnoni 925 Seton Dr. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN UD 2017 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert Lowell Boslev 2010 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Health Care Ctr Frederick Frederick If Under 1 Year If Under 24 Hrs. Funeral Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) ast Virginia 1**X**□ M 2 □ F Months Days Hours Min. onth, Day, Year) 127/1937 Yrs. Director 232-60-2105 West Usual Residence of Decedent 28a-f shov aţ Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland an "natural", or items 23a or 28a-f s Medical Examiner must be notified 1 Yes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 155 B & O Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 <u>truck driver</u> construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Oran Bosley Allie (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Kline / daughter B & O Ave., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baptist Cem. 12/29/2010 | Goshen, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home Jan lu Kri Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) pele Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Physician: The law requires that the death certificate be executed the attending physician and hed for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year cate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \bigcirc No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law i 24 hours after death. Funeral Director: After this certificate has t performed? Yes 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 X No Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes 2 🗆 No ☐ Accident
☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D43091 12-23-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 170 Cenda MO TOLL 30 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN Registrar

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 A M PATRICIA MARTIN BOONE 5:08 DECEMBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-38-0912 1 □ M 2 🔀 F Days Hours Jan. 28, 1941 69 Pennsylvania Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Frederick Jefferson 1 Tes 2 No 10f. Zip Code 21755 10e. Street and Number 10g. Citizen of What Country? United States 3891 Shadywood Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Bank Teller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leo F. Martin Julia E. Wiley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul W. Boone (Husband) β891 Shadywood Dr., Jefferson, MD, 21755 20a. Method of Disposition
1X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Olivet Cemetery 20c. Location - City or Town, State 12/30/2010 Frederick, Maryland 4 Donation 5 Other (Specify) ke eney & Bastord P.A. Funeral Home 106 E. Church St., Frederick, MD, Signature of Funeral Service Licensee MO1612 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner eumonia Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform virtue 24 hours after death.

To the Funeral Director. After this certificate to completed filled in by the funeral director pag Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Tes 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

9

29b. Signature

of death (Item 23a) (Type, Print

29d. Date signed (Month, Day, Year)

2010

2170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Edward Bradburn Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Allegany Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) November 18, 1916 **Funeral** 9. Birthplace (State or Foreign Days Hours Country) Lonaconing Director 061-07-1504 94 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 🗆 No Maryland Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral Kensington-Algonquin, Apt 608, 1 Baltimore Street 21502 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Inspector Highways Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Issac Bradburn Edna Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Bradburn, Jr. - Son 1509 Winners Cup Circle, St. Charles, Illinois, 60174 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 24, 2010 Cumberland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Brand 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician -08 cardivoused disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death signed by the at d be detached for 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has blirector, page 2 s 1 Yes 2 No Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 \(\text{Not} Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner/ To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier December 21,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) a.k.a. Mary Isabell Baumgardner Month DECEMBER Day 7 Physician/ 2010 11:55A BAUMGARDNER ISABELL Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 7. Age (In yrs. last birthday) 83 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Min. Hours Ma(Y^{on}20^{oay,} 11927 Mary land 213-24-9004 1 □ M 2 □X Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10b. County 10a. State filed within 72 hours after death with the Maryland must be notified at **Funeral Director** Frederick Maryland Frederick 1XXYes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21701 items 23a 19 Frederick Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 9 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ပ Mae Lewis should be Martin Draper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1476 Heather Ridge Court, Frederick, MD 21702 19a. Informant's Name/Relationship (Type, Print) Holly Baumgardner, daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery Dec. 23, 2010 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Signator of Foneral Service 22.Reeneral Home 106 East Church St., Frederick, MD 21701 M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYELOPROLIFERATIVE DISURDER PRUBABLE Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown SPENOMEG-ALY Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident
Suicide 1 🔲 Yes 2 🗌 No Investigation within 24 hours after deat

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 🗆

State Registrar only one)

29b. Signature and little of certifier

Lakhvinder Wadhwa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B2. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

DO063498

400 w 7th St Frederick, MD 21701

29d. Date signed (Month, Day, Year)

12/19/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Catherine Orpha Crabtree Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 1 □ M 2 🕅 Days Hours Min (Month, Day, Year) 02/14/1915 Country) Maryland 95 Director 220-07-6382 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked out than "natural", or items 23a or 28a-1 sho amy injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Corriganville 1 🗌 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21524 USA 10903 Kreigbaum Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify 3 ₩ Widowed 4 Divorced White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lapp Martha David Mosser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3459 Blandford Way, Davidsonville, MD 21035 Terry A. Crabtree/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Mem. Gardens 12/17/2010 LaVale, MD 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Adams Family Funeral 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be twithin 24 hours after death.

To the Funeral Director: After this certificate has home sinned by the contract of the c Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number woweeksh 0005534 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nd MP 925 WONSOCK 5HIN

Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Year Month Bettv Jean Cook AM 12:30 Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany 15200 Scarlett Court, SW Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days 1 M 2 X F Hours Min. 216-22-6851 02/01/1927 **Director** 83 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany Cumberland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 15200 Scarlett Court, permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. à 1 Never Married 2 Married ☐ Yes 2 🌠 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates White 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Russell Harry Hilleary, Sr. Powell Leoda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Cook, Jr. / Son 602 Patterson Avenue, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sunset Memorial Park 12/18/2010 Cumberland, MD 21. Signature of Funeral Service Liger 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death CORONARY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PARKINSONISM Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 N of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of **Certificate:** 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

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32. Registrar's Signature

D26907

925 Bishop Walsh Road, Cumberland, MD

Hedm

Name and address of person who completed cause of death (Item 23a) (Type, Print)
 Harjit S. Sidhu, M.D., 925 Bisho

31. Date filed (Month, Day, Year)
UEC 16 2010

December 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav James Leonard Conlon, Sr. 2:50 PM December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Devlin Manor Health Care Center Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 ▼ M 2 □ F Months Days Hours Min 01/2471933 Director 220-28-9666 77 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 802 Edgewood Drive 21502 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 2 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 72 t of health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Owner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Frederick Conlon Catherine Elizabeth Knieriem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Conlon / Wife 802 Edgewood Drive, Cumberland, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If i 1 X Burial 2 Cremation 3 Removal from State injury or S.S. Peter&Paul Cem. 12/14/2010 4 Donation 5 Other (Specify) Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. Signature of Funeral Service Dice adar 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ula Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): /sician and bunial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Li retai acc...
Pregnant at time of death O in the past 12 months?
1 ☐ Yes 2 ☐ No the a signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No Yes 2+ To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 XX Nursing Home 5 \square Residence 6 \square Other (Specify, 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred - Natural 5 Pending injury work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17565 3+ December 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nas Anthony J. Bollino Jr., M.D.,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Morting)

T'4 2010

Maryland 21215-0036

Baltimore,

P.O.

Records,

of Vital

Division

Registrar's Signatur

922 National Highway, LaVale, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Physician/ Rvleigh Christian Cambre1 12 18 2010 4:16 Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brandywine Prince George's 8005 Grayden Lane If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Days 16 (Month, Day, Year 1/5/2010 Hours Min 1 □ M 2 🛣 F Director Maryland Usual Residence of Decedent or 28a-f show 10a State 10b. County be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f shorex Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Brandywine 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8005 Grayden Lane USA 20613 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 √2 Never Married 2 ☐ Married ş Yes 2x X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Black Completed 3 Divorced 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) None other None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Mem. Important: If item 27 is marker any injury or other transmit Richard C. Cambrel Pershelle Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pershelle Greene/Mother 8005 Grayden Lane Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 12/23/2010 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day Year 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 ☐ Yes 2x No Yes 2x x No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2XXN0 ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5x Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number manu Prom MA D0059149 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Prosser 6104 Old Branch Avenue Temple Hills, MD 20748

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 3 2010

10-09679	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, Original Print In
Reed Alexander Cantler	State of Maryland / Department of Health and Mental Hygiene
4 5 00 4	

		Registrar Certificate of Death Reg. No.								
Physici Medical Exami		Decedent's Name (First, Middle,Last) Reed Alexander	Cantler					Day Year r 22, 2010	3. Time of Death 1600 hrs	
		4a. Facility Name (if not institution, give street and number) IFO 18932 Getting Road			b. City, Town, or Keedysville		Death	4c. County of Washingt		
Funeral Director		5. Social Security Number 6. Sex 212-49-9799 1 X M 2	7. Age (In yrs. las	st birthday) Yrs.	Months Days Hours Min.				Birthplace (State or Foreign Country) Maryland	
any		Usual Residence of Decedent 10a. State 10b. County		own or Location	on				10d. Inside City Limits	
yland I-f show	tor	Maryland Washington		Sharpsb					1 X Yes 2 No	
with the Maryland ms 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 17443 General Lee Dri	170		10f. Zip Code 2178	2] 1	10g. Citizen of Wha	·	
with the ns 23a be noti		11. Marital Status 12. Was	Decedent Ever in U.S		Decedent of Hi	spanic Origin?	(Specify Yes or No	o- 14. Race -	American Indian, Black,	
5-0036 ed within 72 hours after death with the Maryland Jygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	by Funeral	Married 2 Married	ed Forces? es 2 X No e Year		Yes 2∭ No		uerto Rican, etc.)	White,	White	
hours a		15. Decedent's Education (Specify only highes			's Usual Occupa est of working life			16b. Kind of Busi	ness/Industry	
5-0036 led within 72 hours a tygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) Colle 9	ge (1-4 or 5+)	Studen	ıt			Educa	ıtion	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last) William Scott Cantler	•				lame (First, Middle,	ŕ		
D 2121 should be fill and Mental F 7 is marked 1 attic event, 1	To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Stree		Elizabet		State, Zip Code)	
e, MD 2 I and 2 shoul Health and In Fitem 27 is nor r traumatic		Ann E. Rice / Mother	T				Drive Sha			
S L E		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removements	val from State cre	ematory or oth		,	Date		City or Town, State	
Baltimo permit. Page Department o Important: injury or oth		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	Boy		sbyteria		2/29/2010		Maryland ral Home, PA	
Dep Derri		that the control to	P	76	06 01d	Nation	ol Piko	Roonshoro	MD 21713	
Physician /Medical	71 74	23a. Part I Enter the disease, or complications failure. List only one cause on each line.		Do not enter th	e mode of dying,	such as card	iac or respiratory arr	est, shock, or hear	t Approximate Interval Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Due to (or	as a consequence of):						Dead	
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or	as a consequence of):							
-	Examiner	cause. Enter Underlying Cause (Ulseass or injury that initiated cuprets resulting in (agth) I ast Due to (or as a consequence of):								
cuted and transit		events resulting in death) Last Due to (or d.								
8760, tificate be executed ng physician and as the burial - transit	ın/Medical	UNPENDED AMEND								
w = = a	an/M	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnative birth	2 Feta	al death 3	Ectopic pro	egnancy	23d. Date of de Month	elivery Day Year	
Box 6	Physicia	A D May o D Halanous I best	regnant at time of deat nknown	th 5 Oth	er (Specify)					
Records, P.O. Box 6 The law requires that the death cer cate has been signed by the attendi page 2 should be detached for use	by Ph	Part II. Other significant conditions contribut	ng to death but not res	ulting in the ur	nderlying cause	given in Part I.			te to the cause of death?	
rds, F w requires s been sign should be	ted							s 2 ✓ No 3 an	ere autopsy findings available	
of Vital Records, by Physician: The law requir ufter this certificate has been some director, page 2 should	Completed						autop perfo 1 ✔ Yes	psy pric rmed? dea	or to completion of cause of ath?	
tal Rectian: The I certificate I ector, page	Be Co	25. Was case referred to medical			26.Place	of Death (Ch		2 10 1	Yes 2 No	
of Vital g Physician: fler this certif	To E	examiner? 1 V Yes 2 No 27. Manner of Death 28a.		R/Outpatient 28b. Time of In		Other No		Residence 6		
- 3 . ~ 2	tion:	1 Natural 5 Pending Dec	Aonth Day Vear)	1550 hrs		Yes 2 ✔ No	belted car o	assenger that	went off road at hi	
Division To the Hospital or Attendition within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	Place of Injury - At hor		, factory, office b	ouilding, etc.	28f. Location (S		or Rural Route Number, City	
Div the Hospital or hin 24 hours aft the Funeral Di		4 Homicide 29a. Certifier 1 CertifyIng Physician: To the			ed at the time, da	ate and place,				
To the Hos within 24 h To the Fur completely	Medical		asis of examination and ner stated.	d/or investigation			ed at the time, date			
	2	29b Signature and title of certifier	1 mgs	0	29c. Licens			December 2	(Month, Day, Year) 3, 2010	
	}	30. Name and address of person who completed	cause of death (Item 2					<u> </u>		
5H-7			Medical Examine		enn Street, E	Baltimore, N	MD 21201			
St Regist	ate rar	31. Date filed (MonDEC 2") 2010	Denne Signature	A pa	w					
DHMH 17 Rev 1/2	001	OCME		ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:05 FM (comber Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death Wastinster ler:tus 120 CWN Social Security Number Funeral 7. Age (In yrs. last birthday) If Under Wear If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Months Hours Min (Month, Day, Yea Country) Missour Director 74 490-34-8132 Feb Ĩ936 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medi al Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 X No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19830 Cool Hollow Road 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force "natural", or þ 1 Never Married 2 Married Black White etc. ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes. Give Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene, other than " Elementary/Seconday (0-12) College (1-4 or 5+) Director of Govt Affairs Podiatric Association and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Robert L. Carson Ellen Larson and 2 should be Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul F. Carson / Son 6019 Harnsberger Barn Ct. Manassas, Virginia 20112 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 12/28/2010 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bast-Stauffer Funeral Home, any. 500lsku 7606 Old National Pike Boonsboro, MD 21713 23a. Part . Enter the disease, or complete shock, or heart failure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical that the death certificate be IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for L in the past 12 months? 5 Other (specify) Month Veal Pregnant at time of death Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 2 No Hospital or Attending Physician: '24 hours after death. 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending n 24 hours after death e Funeral Director; / Accident Investigation 1 Tes completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the F Certifying Nurse Practioner: To the hest of my knowledge d 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11116 Medicol comprised. Meritus 3H-10 BARON CONTR Medical 31. Date filed (Monta 32. Histrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12|16|2010 Physician/ 12:00 p M L. Creamer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Worcester 520 Yacht Club Dr. Berlin Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) West Virginia 1 M 2 X F Days Months Hours Min. (Month, Day 09 18 Director 235-32-0818 Usual Residence of Decedent 28a-f show : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 520 Yacht Club Dr. 21811 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 🛣No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Emidio Galli Libera Palmeri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 Yacht Club Dr., Berlin, MD 21811 Patrick Creamer son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 12|17|2010|Salisbury, Maryland Salisbury Crematory 21. Signature of Funeral Service Licenses Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic disease or condition Medical resulting in death) Examiner man Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending Division 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carou St - Sal. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State arka Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

of Vital

10-09481	
Robert E Clyde	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert E Clyde		Sta - For State	ate of Maryla	and / Depa		Health a				20	110 4191	
Physicia		Registrar 1. Decedent's Name (First, Middle	e,Last)		tinouto oi	Douin		- 1	2. Date of Deat		3. Time of Death	
Medical Examir		Robert E. Clyd	le.						Month December	9, 2010 Year	1856 hrs	
2 1		4a. Facility Name (if not institution	n, give street and nu		T	b. City, Town,	or Location	of Death		4c. County of		
™		Rockawakin Road and				Hebron			1	Wicomico		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 You Months Da	ear If Unde ays Hours	er 24Hrs. s Min.	1	1	Birthplace (State or Foreign Country)	
Director		100-32-8394	1 M 2 F		71 Yrs				March	2, 1939	New York	
any		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Locati	on					10d. Inside City Limits	
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Aaryland 28a-f show 1 at once.	황	MD Wicc 10e. Street and Number	mico	De1	mar	10f. Zip Code			10	Og. Citizen of Wha	at Country?	
or 28	흸	21/02 Molcon E	ond			2187	7.5			U.S.A.		
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f sho eat, the Medical Exeminer must be notified at once.	Funeral Director	31403 Melson F 11. Marital Status	12. Was Dec	cedent Ever in U.		s Decedent of I	Hispanic Ori		ecify Yes or No-	- 14. Race -	American Indian, Black,	
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after o	DY F	3 Widowed 4 Div	orced If Yes, Give Yes		1	Yes 2 🔀 1	No specify	<i>:</i> :		Specify:	white	
nours.		15. Decedent's Education (Spe-	cify only highest gra		16a. Deceden during m	t's Usual Occup ost of working I	pation (Give ife. DO NOT	kind of wo	ork done ed)	16b. Kind of Busi	iness/Industry	
6 n 72 h	jet Et	Elementary/Secondary (0-12)	College (1-4 or 5+)								
5-0036 led within 72 dygiene. other than '	Completed	12 17. Father's Name (First, Middle,	Last\		Profe	ssional	_			Maiden Surname)	Training	
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nore, MD 21215-0036 ges I and 2 should be filed within 7 nt of Health and Mental Hygiene. It: If item 27 is marked other than other traumatic event, the Medica	의	Howard Clyde, 19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address (St				nber, City or Town	, State, Zip Code)	
MD d 2 sho tith and in 27 is	7	Todd Clyde (S	Son)		403 W	alnut (Court	Dag	sboro,	DE 1993		
e, M 1 and 2 Health Titem 2	ı	20a. Method of Disposition	. 🗆		Place of Dispos crematory or ot		cemetery,		Date	20c. Location - 0	City or Town, State	
Baltimore, sermit. Pages 1 a Department of He Important: If its injury or other t		1 Burial 2 X Cremation 4 Donation 5 Other Sp			•		marwa	12-1	7-2010	Delm:	ar, Delaware	
Baltimo permit. Page: Department o Important:	ı	21. Signature of Funeral Service	Licensee		22. N	lame and Addre	ess of Facilit			neral Ho		
E.E.S. & OD	-	Pines Show	t-Jews	ll	13	East (Grove	Stre	et De	lmar, DE	19940	
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that on each line.	caused the death	. Do not enter t	ne mode of dyir	ng, such as o	cardiac or	respiratory arr	est, shock, or hear	rt Approximate Interval Between Onset and	
/Medical Examiner	1	Immediate Cause (Final disease	N 6 - 163 - 1 - 1 - 1	juries							Death	
		or condition resulting in death)		a consequence o	of):							
7.	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence o	of):							
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Box 68760, e death certificate be the attending physicied for use as the buried for the buried for use as the	1	23b. Was decedent pregnant in the past 12 months?				tal death	3 Ectop	ic pregnar	ncy	Month	Day Year	
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y the de	Physician/Me	Part II. Other significant condit	9OIKI	to death but not r	reculting in the	inderlying caus	e given in P	Part I	23e Did to	phacco use contrib	oute to the cause of death?	
Division of Vital Records, P.O. B ral or Attending Physician: The law requires that the d its after death. **I Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached.	ě	Atherosclerotic Cardi			ocalang ar are	and only mig dead	giroiiiii			s 2 🗸 No 3		
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Of Ving Physical After thi	2	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of		njury at Wor			how injury occurre	-	
OD C	Certification:	1 Natural 5 Pen	uling	h Day Year) 2010	1850 hrs	1[Yes 2 ₩	∕ No	Driver ran o	off road and st	ruck a tree	
rision rate describerto	fica		stigation 28e. Pla	ce of Injury - At h	nome, farm, stre	et, factory, offic	e building, e	etc.			er or Rural Route Number, City	
Division of the control of the contr	핗		median di la la la la la la la la la la la la la	Local Stre	et				or Town, \$ Rockawakin I	State) Road and Nantic	coke Road, Hebron, MD	
Hosp 24 ho Fune		20a Cortifier	hysician: To the be	est of my knowled	dge, death occu	rred at the time	, date and p	lace, and	due to the cau	se(s) and manner	as stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	Medical		iminer: On the basis and manner		and/or investiga	tion, in my opin	nion, death o	occurred a	t the time, date	and place, and du	ue to the cause(s)	
->-	Σ	29b. Signature and title of certific	er /	7/1	MOSE		ense numbe	er			ed (Month, Day, Year)	
γ_{Λ}		Julo 3	atter 1	/eeb	1	0.	C.M.E.			December	10, 2010	
EN		30. Name and address of person	•	_ '		O	Daltino	** P4D	21201			
7		Victor Weedn MD JD	Assistant M	P		Penn Street	, Baitimo	ie, MD	Z 120T			
St Regist	ate :rar	31. Date filed (Month, Day Year)	2010 2	Registrar's Signat	a. Spar	Ked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ JOSEPHINE CHEJNE DECEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday **Funeral** Jann. 3ay, 79919 Days Hours Min. Pennsylvania 1 🗆 M 2 💢 F **1**19-22-5079 91 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State Director 1 Yes 2 □ No New Market MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21774 404 Tailor Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>0</u> Florence Ricca Michael Marinelli | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 404 Tailor St., New Market, Maryland 21774 19a. Informant's Name/Relationship (Type, Print) Cecilia Maddlone (Daughter) Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 12/21/2010 Smithsburg, Maryland Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) Keeney Kobasford P.A. Funeral 106 E. Church St., Frederick, 21. Signature of Funeral Service Licenses Home Maryland 21701 MO1612 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Onset and Death Immediate Cause (Final Ph sician/ ROUT heumonia disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to for as a consequence of: il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed transi and Due to (or as a consequence of) resulting in death) Last the attending physician a hed for use as the burial-Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2. No 9 Unknown this certificate has been signed by the rail director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? iver 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to the rical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d, Describe how injury occurred 1 Natural (Month, Day, Year) work?
1 Yes 2 No injury 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Meg/cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only p nd title of certifie 2 29d, Date signed (Month, Day, Year) 2010 mod 65378 pleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Date filed (Month.

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 9:19 PM Beverly Ann Clark Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Kline Hospice House Mount Airy If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** May 18, 1951 Hours 59 North Dakota **Director** 502-62-1779 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1X Yes 2 ☐ No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 United States 1301 Motter Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 N Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Phyllis Johnson Harold Krueger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 Motter Avenue, Frederick, Maryland 21701 Julie Clark / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 X Burial 2 Cremation 3 Removal from State Dresden, North Dakota Reedeemer Lutheran Cem. 28, 2010 4 Donation 5 Other (Specify) Keeney and Basford PA Funeral Home, 106 E. Church Street, Frederick, Maryland 21701 21. Signatul of Funeral Service Licensee m MO1473 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the dis Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Interval Between Onset and Death cancer Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-transit law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has i rector, page 2 s autopsy performed Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 M No 26. Place of Death (Check only one) funeral director, Be MOSTICE HOUSE Other: 4 Nursing Home 5 Residence Other (Specific 1 Inpatient 2 ER/Outpatient 3 DOA မ this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV. Frederick MD 2/7/1 shelh Tohnson shamas

Registrar
DHMH 17 Rev 7/2009

State

32. P gistrar's Signature

10-09509 Samuel Corrice Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 4 92

State of Maryland / Department of Health and Mental Hygiene Samuel Corrice 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ William Corrice 1915 hrs Samuel. December 10, 2010 **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's 13428 Lord Dunbore Place Upper Marlboro 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign CountryNew Jersey Months Days Hours 154 38 1222 Director March 2, 1950 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location Prince George's Upper Marlboro 1 Yes 2 X No Maryland notified at once, Director 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 20772 13428 Lord Dunbore Place United States 238 Funeral 11 Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. Armed Forces 2XX Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiens.
Department of Health and Mental Hygiens.
Department of Health and Mental Hygiens.
Department of Health and Mental Hygiens.
Department of Health and Mental Hygiens. 4 Divorced If Yes, Give Yeer 1 Yes 2 XX No specify: Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SNS Engineering 12 Civil Engineer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 8 Beatrice Hulley Emeral Corrice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 1411 Pimpernel Drive, Waldorf, MD 20603 Barbara Corrice (Wife) 20a, Method of Disposition

1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Dec 17, 2010 Milford, New Jersey Mount Pleasant Cemetery Donation 5 Other Specify: 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licensee Ferry Road, Clinton, MD 20735 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Martical Death Atherosclerotic Cardiovascular Disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED 23a,pt.II,27 per me g911 1-20-11 vt ned by the attending physician a detached for use as the burial X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy Was decedent pregnant in the 2 Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? হ 1 Yes 2 ✔ No 3 Probably 4 Unknown History Of Seizure Disorder Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? page 1 🗸 Yes After this certificate ✓ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medica** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 11, 2010 rell 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
#568 Per FH G911/26/2011 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **2010** Year December 27 12:37 Thomas Edward Crummitt, Sr. A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel al-Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Scape Feithber 24, 1933 irthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Days 1 X M 2 🗆 F 212-28-2238 77 Director 27, 2010 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Queen Anne's Grasonville 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 Grasonville Terrace 21638 United States of America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 X Married Yes Yes, Give Completed by 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3
Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Septic Excavator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Thomas Crummitt Bessie Hurst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Edward Crummitt, Jr. / Son 10506 Gas House Pike, New Market, Maryland 21774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 30. permit. Page 1 Department of Important; If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2010 Smithsburg, Maryland Signature of Funeral 22 Name and Address of Facility Keeney & Bastord P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) neumoni Medical Due to (or as a consequence of): ∛Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that inflicted events. Examiner Duri to (or se a consequence or): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has autopsy performed^a 2 🗌 No __ Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner's Certificate: To 1 Yes Other: 20 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) 58510 wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) phen 31. Date filed (Month) 32. Registrar's Signatur State Registrar DHMH 17 Rev 7/2009

DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ~ Day 13 Physician/ Month 0415 M Cheryl Durham December 2010 R. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 4703 Old Soper Road #553 Camp Springs 8. Date of Birth (Month, Day, Oct. 21 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Country)
NC 1 □ M 2 😾 F Months Days Yrs Director 579-84-1301 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No PG Camp Springs MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4703 Old Soper Road #553 20748 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or iter Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify:Black Completed 3 🗌 Widowed 4 🙀 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Government Paralegal Supervisor and Mental Hygie is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie L. Williams Herbert Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
568 Foxhall Place, SE
Washington, DC 20032 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trat once. Annie L. Johnson/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 😾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 12/17/10 Brentwood, Md. 21. Signature of Funeral Service License 22. Name and Address of FacilityHodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1. Enter the dis ast, or complications the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one quiscon each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes ∠ ▼ 9 ☐ Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? page 2 the Hospital or Attending Physician: The Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Hospital: Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \(\sum_{\text{Nursing Home}} \) 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? ■ Natural injury 5 Pendina 124 hours after death.
Funeral Director: After leted filled in by the fun 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) REXFO 3470 ANNAPOLIS ROAD, #306, LAI Mr 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

DEC 2 2 2010

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierfe - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12 2010 0235 M noaene /Medical 4a. Facility Name (If not institution, give street and humber 4c. County of Death 4b. City, Town, or Location of Death Examiner Bowie Bowie rince Georges If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2 F 579-40-2495 **Director** 80 March 30,1930 Wash., DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-1 show other treumatic event, if a Medical Examinar must be notified at 1-Yes 2 □ No Completed by Funeral Director MD PG Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7410 Old Chapel Drive 20715 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after I ☐ Yes 2 ☐ No I Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. important: if fiem 27 ie marked other treumatic even. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) School Teacher Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Johnson 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7410 Old Chapel Drive Stella Williams/daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Heritage Memorial Cem. 12/20/10 Waldorf, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 unce Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 60 min disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner V Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit ocar that initiated events resulting in death) Last led by the attending physicien and detached for use as the burial-tran Due to/(or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No 24a Was an has autopsy performed? certificate 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 XNo 1 🗌 Inpatient 2 R/Outpatient 3FT DOA this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

Denova

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

05120

December 13, 201 15001 Health Contin Drive BowlemD

207/10

Bowie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec 1^{Day}. 20°10 01:10 Ам Jimmie Lee Davenport Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton, Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days Min. Months 169747/1943 Wagner, S. Carolina **Director** 577-56-4655 67 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 No Maryland Prince Georges District Heights, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 United States 2107 Marbury Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian. Armed Forces? Black, White, etc. Specify: Black þ 1 Never Married 2 X Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ll Hygiene. I other than " Elementary/Seconday (0-12) 12 College (1-4 or 5+) Self-Employed Tour Guide should be filed with and Mental Hygier 7 is marked other t injury or other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Sadie Davenport Eddie Gantt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2107 Marbury Drive, District Heights, MD 20747 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Cynthis Davenport 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 12/18/10
Riverdale Park Crematory 1 Burial 2 XCremation 3 Removal from State Riverdale, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee PoplemerndAddres If Fromes, PA, 5538 Marlboro Pike emmons <u>Forestville, MD</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Acute Atheroscierune Cardiovaschiar Diseasea Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami Cause (Disease or linjury that initiated events Diabetrase Malliatus Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY BYDGSS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗚 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of ce berovasema Accident autopsy performed? Yes 2 N death? 2 🔽 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔛 Natural 5 Pending of the safer death.

E Funeral Director: After the further of the further the 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funel completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number am. m 50689 12/15/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILK MAHAS AN MD southern maryland 7503 Road Charon MD 20731 SHAVAHS 31. Date filed (Month, Day, Year) DEC 2 2 2010 Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 14, 10:10 A M Jeannie Annette Dickey December 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c County of Death **Examiner** Homewood At Williamsport Williamsport Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months Days **Director** 492-26-8485 91 11/10/1919 Kansas Usual Residence of Decedent 10a State 10b. County 10d Inside City Limits show 10c. City. Town or Location event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No 28a-f Maryland Washington <u>Williamsport</u> 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō 23a 16505 Virginia Ave. 21795 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: or items, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify þ 3 Widowed 4 ☐ Divorced "natural" White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other trauments. Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles Leland Nav Kempf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lynn Dickey / Daughter Tattershall Ct. Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 12/17/2101 | Smithsburg, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Protosth disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) detached 9 ☐ Unknown signed { Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Tue 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🖪 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the nosperior.
within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D (80 (9 net mo (4, 201) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740 VASANT DATTH NO 340 MILL ST MAKERSTOWN MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Capies Are Legible.
Amend Item 1 per med cert G911 1/5/11 ak
State of Maryland / Department of Health and Mental Hygiene 2 1 1

items 23a,b,27,28a-f per me. g912 2-7-11 vt

Certificate of Death

Reg. No. 1 - For amend items
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bruce Durost 3. Time of Death Physician/ Month 600 2010 М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Allegany Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) ME Month 27, 1949 1 🗆 M 2 🗆 F 049-40-3259 Yrs Director 61 Usual Residence of Decedent 28a-f shov Examiner must be notified at 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits Director WV Fort Ashby Mineral 1 Yes 2 XNo 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a P.O. Box 59 26719 USA or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: "natural", Specify 3 Widowed 4 Divorced white Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) event, the Public School System school bus driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Nelllie Craig Wilson Everett Durost 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 59 Fort Ashby WV 26719 Diana Durost wife item 27 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Life Quest Anatomical 12/21/2010 Whitehall PA 4 Donation 5 Other (Specify) Sonatur of Funeral Service Licenses 22. Name and Address of Faulteral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Peath Part 1. Enter includes ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or superatory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition Physician Medical resulting in death) Examiner Multiple Motor Vehicle Accidents Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IE EEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? jo Month Day Year the detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 \square Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Yes 2 🗹 1 Yes the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of injury s after death. I Director: After ti 28c. Injury at 28d. Describe how injury occurred ural 5 Pending 2 X Accident 1 Yes 2 K No 1966 multiple motor vehicle accidents unknown M Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) unknown unknown within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 30. Name and address of person leted cause of death (Item 23a) (Type, Print) 925 M.I SUISITE WAGGINER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore,

68760

Box

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ 4: 00M 10 eman RACPH 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UPPER CHRIAPPARE MUDICAL CONTAN MARYLAND HARFORD RER AIR If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8 Date of Birth 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Months Hours Min 3/14/1 Maryland 220-34-6932 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b County 10c. City, Town or Location Director notified 1 ☐ Yes 2 🎇 No Forest Hill MD. Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a United States 1345 W. Jarrettsville Road 21050 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ò þ 21215-0036 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Lumber Store Co-owner Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H ည permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic. Arthur McClung Edie Gladys 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 19a. Informant's Name/Relationship (Type, Print) Jarrettsville Rd. Forest Hill, MD. 1345 W. (Wife) Ann K. Edie 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Madonna, Maryland 2010 Bethel Cemetery 22. Name and Address of Facility E.G. Kurtz & Son Funeral Signatu Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PRUBABLE ACURE MYOLARD DAL INFARCTED Physician/ disease or condition Medical resulting in death) Examiner MURGO Securitally let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): RUBABUE Due to (or as a consequence of) resulting in death) Last the burial Physician/Medical IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Day 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The law performed 2 🗌 No Yes 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Division of Vital Other: 2 🗷 No 1 Yes 1 Inpatient 2 / 4 Nursing Home 5 Residence 6 Other (Specify) ည ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manne of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending after death.

Director: Af 1 Tyes 2 🗌 No 2 Accident
3 Suicide
4 Homicide investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Centum Nurse Practiciner To the cost of my months of the cause of the firm, date and class and manner as stated. unity unit) 29b. Signature and title of certifier 00065966 SCO UPPER CHOSARDAKO M. BOL ADR. M. 2101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Register's Signature State

27 DHMH 17 Rev 7/2009 200

Registrar

James Franklin Fox

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 | 93 | State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg. No.											
Physici	an/	n/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Til									3. Time of Death	
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			on, give street and r	umber)	"		Location of	Death				
		906 E. C Street Brunswick Frederick										
Funerai		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Yea			B. Date of Bir	th(MM/DD/YYYY	9. Birth Foreign	
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21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	Be	Arthur Frankli	n Fox				Yvonr					
D 21215-0036 ashould be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked ather than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once.	70	19a. Informant's Name/Relation	ship (Type, Print)		7.5					nber, City or Town		
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. ut: If item 27 is marked ather than "natural", other traumatic event, the Medical Examiner.		Mary A. Hurst/	Wife		906 E	. C Stre	eet. E	3runs	wick.N	aryland 20c, Location -	217	16
Heal item		20a. Method of Disposition			Place of Disposi rematory or oth	tion (Name of cer	netery,	D	ate	20c. Location -	City or 1	own, State
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tiner trans		4 Donation 5 Other S 21. Signature of Funeral/Service		Sta	uffer C	rematory	/ Ind.	12/2	0/2010	Frede	rick	.Maryland
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumat		21. Signature of Funeral Serve	e Licensee	//	Sta	auffer F	unera.	1 Hon	ne P.	Α.		yland 21702
	,	23a. Part I. Enter the disease, o	voju		162	1 Opossi	ımtown	ı Pik	e, Fre	ederick,	Mar	yland 21702 Approximate Interval
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P.O. Box 68760, es that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit			0									
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760, ficate be physic the bur	W/	IF FEMALE: 23b. Was decedent pregnant in t		, outcome of pregr		_ [¬			23d. Date of		
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Box 687 he death certification of the attending seed for use as t	Physician	1 Yes 2 No 9 Ur	nknown 9 Unk		ath 5 Oth	ner (Specify)						
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Division of Vital Records, To the Hospital or Attending Physician: The law requirements after death. To the Funeral Director: After this certificate has been seem to completely filled in by the funeral director, page 2 should	Medical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pen 2 Accident Inve 3 Suicide 6 Coudete 4 Homicide 29a. Certifier (Check only one) 2 Medical Excending Accident Medica	Hospital: 1 28a. Data FOUND 28b. Platemined 2b. Platemined	e of Injury th Day, Year) 3, 2010 ce of Injury - At ho ce of Injury - At ho ce of my knowledge of examination ar stated.	28b Time of In FOUND: 1945 hrs Ime, farm, stree Ime, death occurrend/or investigation 23a) Examiner	3 DOA njury 28c. Injur t, factory, office because the time, date on, in my opinion 29c. Licens O.C.1	Other or y at Work? Yes 2 1 1 ouilding, etc. ate and place, death occurrent occurren	Nursing H 28 Su 28 900 se, and du urred at th	autor performance of the cause	Residence 6 No 1 Residence 6 No 1 Residence 6 Residence 6 Residence 6 Residence 6 Residence 6 Residence 6 Residence 6 Residence 6 Residence 6 Residence 6 Residence 6 Residence 6 Residence 7 Residence 6 Residence 7 Reside	Other: ed efire Other or Rura MD as state to the ded (Month)	Scene al Route Number, City d. cause(s) h, Day, Year)

DHMH 17 Rev 1/2001

Physician	
/Medical	
Examiner	

Funeral

Director item 27 la marked other than "natural", or Itams 23a or 28a-1 show othar traumatic event, the Madical Examinat rought by multified at and Mental Hygiene. should be fund Mental I

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

permit. Pages Department of Important: If it any injury or o

Pages 1 and 2 s ment of Health an ant: If item 27 la

use as the burial-transit attending physician the detached ò certificate has funeral director, page 2 this

Physician: The law requires that the death certificate be executed

or Attending

after death

24 hours a

filled in by the

completely To tha

Division of Vital Records, P.O. Box 68760

1 - For State Registrar Certificate of Death 2. Date of Death Month 12 10 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10 2010 Augustus Mustapha Freeman 9:20 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Nursing Home Silver Spring Montgomery | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 08/06/1936 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 1 M 2 □ F 579-06-0530 74 Yrs. Liberia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Takoma Park MXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7620 Maple Avenue apt.#310 20912 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ¥ENever Married 2 ☐ Married Specify: Black If Yes, Give Year or Dates: 1 Yes 20XNo Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) The Ministry of Elementary/Secondary (0-12) College (1-4or 5+) Accountant Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bokai Freeman Marian Paasewe ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Famata Fahnbulleh/Granddaughter 1233 Climbing Ivy Dr., Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolatin Crematory01/10/2011 Alexandria, VA * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTICEMIA disease or condition resulting in death) Due to (or as a consequence of): THE BLADDER Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury DIARETES that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 1 ☐ Yes 2 🔀 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical The Destroying Physician: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 ☐ Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) DECEMBER14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 73257

State Registrar JICIOR

31. Date filed (Month, Day,

DEC 2

32. Registrar's Signature

Horoloves

GREGORBELT MARY LAYER 20770

ONVEJIAKA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Problem #20b.PerFHPCC12-29-10cm 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year Month Physician 19 10:10 a^M Dec 2010 PHILLIP FLOWE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Hospital Prince Georges Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 X M 2 □ F Director 577-46-1198 74 Mar. 10, 1936 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show notified at 1 ☐ Yes 2√ No Director MD Prince Georges 23a or 28a-f Ft. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Examiner must be Funeral 1800 Palmer Rd. 20744 USA filed within 72 hours after death Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1959 -1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☒ No ģ Specify: 3 ☐ Widowed 4 X Divorced Black Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th PG County Circuit Court Baliff 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve Eugene Flowe Pages 1 and 2 should ၉ Lillian Cunningham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Divers - Sister 9801 Ambler Lane Upper Marlboro, MD. 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem $1-3-\frac{2011}{2010}$ 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD. 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER TERMINAL Physician ORAL UNKNOWN /Medical Due to (or as a consequence of): Examiner ACUTE. ANEMIA UNEKNOWY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe Yes 2 certificate I 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3□ DOA ၉ 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending investigation thin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

CR 8+1

State Registrar 30. Name and address of per

31. Date filed (Month, Day, Year)

DEC 2 3 2010

DHMH 17 Rev 1/2001

LIVINGSTON Rd

n who completed cause of death (Item 23a) (Type, Print)

11701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Caroline Anne Fletcher Month 2010 Dec. 4:63 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7101 Cipriano Spring Drive Prince George's Lanham 7. Age (In yrs. last birthday)
57 ~~ 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days 1 □ M 2 🗓 F Months Hours Min Director 213-98-0868 Nigeria Lagos, Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Lanham 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7101 Cipriano Spring Drive 20706 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hotel Manager Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Molly A Johnson and Mental H permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Rowland Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Fletcher (brother) 6907 96th Ave. Lanham, MD 20706 Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 12/23/2010 Brentwood, MD 21. Signature Fungal Serv 22. Name and Address of Facility Fort Lincoln Funeral Home who 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ Metastatic disease or condition resulting in death) unknows - Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month 1 Yes 2 9 Unknown n signed by the a Id be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24a. Was an 24b. Were autopsy findings available this certificate has braid rail director, page 2 s autopsy prior to completion of cause of death? performed?

1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🖾 No 2 Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: I Director: After to in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 December 22, 2010 Do*33299* Washing ton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene [] State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jane Virginia FORREST 2010 4:54 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
June 6, 1934 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 XF Hours 218-30-9236 Maryland 76 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Boonsboro Maryland Washington 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21713 20928 San Mar Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 X Married Completed by Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant; If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) clerical work telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn L. Cole Leroy E. Harshman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20928 San Mar Road, Boonsboro, Maryland 21713 Richard L. Forrest - husband 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Rest Haven Cemetery 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State Hagerstown, Maryland 12/28/10 4 Donation 5 Other (Specify) Signalus of Funeral Service Licen 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Perforate Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 30 months 1 Yes 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide within 24 hours after death

To the Funeral Director:

completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Frantioner: To the best of my knowledge, death notified at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \sim M) 31. Date filed (Mo egistrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Fundeneanu Month **Physician** ristina 17 2010 December 4115 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Dec. 7, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** ^{Year)} 1954 1 □ M 2 🔀 F Days 631-12-6432 56 Yrs. Dec. Director Romania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic event. " 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits VA Director Fairfax 1 ☐ Yes 2 X No Fairfax 10e. Street and Number 4237 Lower Park Dr. 10f. Zip-Code 10g. Citizen of What Country? 22030 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify Specify: White ş 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4 or 5+) Economist Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stefan Nicolescu Elena Neagu ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adrian Fundeneanu/Husband 4237 Lower Park Dr. Fairfax, VA 22030 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Gardens Cemetery | 12/21/10 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Murphy FH 4510 Wilson Blvd. Arlington, VA 22203 Approximate Interval Between Onset and Death **Physician** non 5mall Cell disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any cause. Enter Underlying Cause (Disease or injury Examiner Dividito for as a consection de di or Attending Physician; The law requires that the death certificate be executed that initiated events nding physician and use as the burial-tra resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months? o Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 1 🗌 Yes 2 14 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) after death.

Director: After this 5 Residence funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 2 Accident 1 Yes 2 No filled in by the 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) RES- 000 December 17 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jacqueline Deanna Wilson 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend 73a, 27628a-f per OCME G911 1/5/11 dk
State of Maryland / Department of Health and Mental Hygiene? State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November ALLEN FOOSNESS 2010 6:20 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** Months Days Hours 218-15-7746 June 9, 1977 33 Minnesota Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director Middletown Maryland Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21769 United States of America 4432 Valley View Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 X Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Electricial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Timothy Foosness Yolanda Scheall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Foosness / Mother 4432 Valley View Road, Middletown, Maryland 21769 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 11. 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Zion Lutheran Church 4 ☐ Donation 5 ☐ Other (Specify) Middletown, Maryland Cemetery 2010 22 Name and Address of Facility Keeney & Bastord P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 MO1433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final M Onset and Death Physician/ HNOK disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Multiple Drug Intoxication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Birth 2 Pregnant at time of death Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an his certificate has to director, page 2 sl autopsy performed' death? 2 🗆 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 🗌 No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of injury found, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Suicide 1 ☐ Yes 2 🙀 No n 24 hours after death le Funeral Director: A pleted filled in by the f unk Unknown Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at home 28f. Location (Street and Nuraber on Rural Route Number City or Town, State) Middletown, MD found 4432 Valley View Rd 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 3 within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier urikova, ME MDD 65443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elena 400 Frederick, mo Kova

DHMH 17 Rev 7/2009

State

Registrar

310

32. Registra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 1430 Dec. GAMBLE WILLIAM C. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince Georges Prince Georges Hospital Cheverly 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 1 🕱 M 2 🗆 F Months Days Hours Min (Month, Day,) Country) Director 76 Oct. 238-46-6834 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter and once. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Prince Georges Bowie 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20721 USA 704 Faraway Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black White etc. 1 Never Married 2 X Married þ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Completed 3 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Western Union 12th Messenger Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zelephia Bethea Cleveland Gamble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Faraway Ct. Bowie, MD. 20721 Laura Gamble - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Lincoln Memorial Cem | 12-30-2010 | 4 Donation 5 Other (Specify) Suitland, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death CARDIAC ARRHYTHMIA Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 **N**O ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) n 24 hours after deaun.

ne Funeral Director: After th Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practicy 1: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one) 29b. Signature and Aft ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad HOSPITAL 3001 Mclesky 32. Registar's Sig State 3 DEC 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December <u>Marv Patricia Geremia</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Jown, or Location of Death County of Death ENTER HARLE Social Security Number If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** . Age (In yrs. last birthday) 8. Date of Birth 1 🗆 M 2 🗶 F August 22, 193 Washington, **Director** 578-40-2863 79 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director XX Yes 2 No LaPlata Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11990 Provident Drive 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Be Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after 1 Yes 2X No Specify. Specify: White "natural", 3 X Widowed 4 □ Divorced Year or Dates nt of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th. Food Manufacturing Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Patrick Francis Ryan Bridget McCabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Geremia/ Son 12475 Old Colony Dr. Upper Marlboro, MD. 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dec. 15, 2010 Bryantown, MD. Mary,s Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death caemia Physician/ disease or condition Medical resulting in death) Due to (or as a consequ Examiner Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Director: After this in by the funeral di 28b. Time of 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined 24 hours Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one Signature a 30. Name a death (Item 23a) (Type, Print) at 051 Thu Registrar's Signatur State 2 2 Registrar

State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month P^{M} Anna Delilah Gossard Dec<u>ember</u> 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport Nursing Home Willi<u>amsport</u> Washington County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Days Hours July 16, 1912 98 Marvland Director 213-68-6749 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Washington County Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33 S. Main St. 21722 U.S.A death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married ģ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify: Specify: White "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Thomas Murray Mary Russell Roney Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Dean L. Gossard-son 11903 Ashton Rd. Clear Spring, MD 21722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 12-31-2010 | Hagerstown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that edused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Tes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural n 24 hours after death.

e Funeral Director: Afteleted filled in by the fur 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🛮 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 33750 December 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH-5 WILLIAMSPORT, MD 21795 N. ARTIZAN 75 4al STIZEET Fegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 1 per med cert G911 1/11/11 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Esther Month Day hysician/ 10:00 P M 2010 Esther Patricia Ann Guhr Dec. Patricia Ann GUHR Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death xaminer Williamsport Retirement Village Williamsport Washington If Under 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, 1 🗆 M 2 🕱 F Months Days Hours Min. 82 Director Nov. 1928 West Virginia 233-44-5466 Usual Residence of Decedent 10b. County 10d. Inside City Limits death with the Maryland 10a. State 10c. City. Town or Location Director notified 28a-f 1 X Yes 2 No Maryland | Washington Hagerstown 6 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 11 W. Baltimore Street Apt. 413 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or iter Armed Forces?

1 Yes 2 X No Black White etc. ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) not mental Hygiene.
s marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 11 Food service worker Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) in and Mental h ဂ Clifton Leo McDonald Esther Sirbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 : If item 2 or other 1 Karen Hudson - Daughter 339 Jopa Road, Greencastle, Pa. 17225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State Rose Hill Cemetery 12/27/10 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signa ure f Funeral Service License 22. Name and Address of Facility Minnich Funeral Home ma 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Physician/ ADENOLARCINOMA disease or condition resulting in death) MONTHS Medical Due to (or as a consequence of) Examiner Seque, tially liet our ditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🔀 No Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RECEMBER 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-2 154 N. ARTIZAN WILLIAMSPORT. IEDE, HOWE 31. Date filed (Month, Day, State Registrar

Edah

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 1200PM Irvin Aaron Garfinkel December 10,2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner is Dun ICOMICO Dalisbury Rehabilitation Nursingto Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Jan. 12, 1919 **Funeral** Days Hours 1⊠M 2□F 91 Maryland 218-01-4192 Jan. Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 28a-f show 14 Yes 2 □ No Director Salisbury MD Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21801 300 Lemon Hill Lane Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 2 Yes 2 No 1942

If Yes, Give Year or Date 2 1946 Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 21215-0036 Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Salisbury Manufacture Sales Representative 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Rebecca Miller Benjamin Jacob Garfinkel ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 4615 Pheasant Dr. - Salisbury, Maryland 21804 Harvey E. Loony/ Son-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 12/17/2010 Salisbury, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of pach line. nter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) Calls NA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year for 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 Unknown à s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy 25. Was case referred to medical examiner? 26 Place of Death (Check only one. Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760, within 24 hours a

Registrar

State

29b. Signature and title of certifier

Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Er 32. Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20°10 825PM 51 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ster 2414 Sishopville LA K C If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year)1931 NOV. TO 1 □ M 2 🗓 F Months Days Hours MARYLAND Director 217-26-7957 79 Usual Residence of Decedent 23a or 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MARYLAND WORCESTER BISHOPVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12414 NORA LANE 21813 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: WHITE 3X Widowed 4 □ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WILLOUGHBY HOGGARD AMELIA SNYDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE BILHEIMER/DAUGHTER 553 SARAH AVE., LINTHICUM, MARYLAND 21090 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ZION CHURCH CEMETERY 12/16/10 BISHOPVILLE, MD 4 Donation 5 Other (Specify) Fineral Service Liconsee 21. Signatur 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease of linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an has ; page 2 autopsy perform prior to completion of cause of death? certificate 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: No မ 1 🗌 Yes 🤊 1 Inpatient 2 ER/Outpatient 3 DOA After this 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? Natural 5 Pending n 24 hours after death e Funeral Director; A 2 Accident
3 Suicide 2 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a, Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one the 29d. Date signed (Month, Day, Date filed (Month, Day, DEC

Registrar DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month December 26, 2010 10:10 Physician/ Gloria Emma Green Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Egle Nursing and Rehabilitation Center Lonaconing Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | December 08, 1923 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In vrs. last birthday) 1 - M 2 X Director 214-28-6629 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1

Yes 2 □ No Maryland Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 90 Douglas Avenue 21539 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 ⋈ Widowed 4 □ Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Samuel Neat Mary Brown permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon Green - Son 90 Douglas Avenue, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Decembe 20c. Location - City or Town, State 1 📈 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Cemetery Lonaconing, Maryland 29, 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death STIVE Ph sician/ neart one Medical resulting in death) **Examiner** 7640815 if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death
Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by allure 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autonsv performed?

Yes 2 No 1 Yes 2 No To the Funeral Director; After this certifica completed filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗹 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury work? 1 ☐ Yes 2 ☐ No. 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland Roan 92en nord 321 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Year Eva Μ. Haas December 1411 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Aug 28, 1933 9. Birthplace (State or Foreign Country)

Germany 7. Age (In yrs. last birthday) Funeral Months Days Min 577-64-4190 Aug **Director** Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified (1 🗌 Yes 2 🔀 No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4408 Colfax Street 20895 Germany 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 X Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be need and 1 and 1 ment and Menta Albert Schmidtke (unk) Lingstadt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred S. Haas/husband 4408 Colfax Street Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 12/10/10 Woodbine, Maryland permit. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 anita Beverly L. Heckrotte, P.A. Clarksville, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MECACOLON Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (coast) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 1 ☐ Yes ∠yz 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an yes 2 No 2 **P**Ro 1 Yes Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🕍 No Other: 은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionar T. The Company of t (Check 29b. Signature and title of certifier 29c. License number DOOS 12/10/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Maryland 20850 Truong Bao, M.D. 10110 Molecular Dr # 206

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Registrar

31. Date filed (Month, Day, Year)

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32. B. gistrar's Signature

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7	Funeral		5. Social Security No	umber	6. Sex	7.	Age (In yrs.	last birthday)		ler 1 Year	If Under Hours		8. Date of Bi	rth	Baltimore 9. Birthplace (State or Foreign				
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'	or iter	by Fu	11, Marital Status 1 ☐ Never Marri	ied 2.1⊠ Mar	Ar	as Decede med Force Yes 2		.S. 13.	Was Dec If Yes, sp	edent of H ecify Cuba	ispanic Ori in, Mexican	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	-	14. Race - American Indian, Black, White, etc.				
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If items 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Seco		1	ollege (1-4	or 5+)	1	_	se retired)	Ü			Ow	n Ho	Home			
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09	eath certificate be ex attending physician for use as the burial	Physician/Medica			d														
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Box 68760	eath c atten for u	iciar	in the past 12 n	nonths?	4 [Pregnan	h 2 🗌 Fet t at time of		Ctopic Other (pregnanc specify)	У					onth	Day Ye	ear	
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Division of Vital Records,		Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Stree City or Town, S											er or Rural	Route Number	r,			
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	ithin 2 o the		only one) 3 29b. Signature and t		Nurse Prac	tioner: To t	ne best of m	y knowledge,		urred at the	-	and plac	e, and due to th			anner as st d (Month, i			
	- ≶ - ō		•		<						757	3			_		-	10	
5		1	30. Name and addre	ss of person v	vho complete	ed ause o	death (Iten			- 1		'n	2)	-			13,20		
/17			Jef	S' /	W //	-	<u> 728</u>		5 m ³	th 1	tre	12	attimo	s-e	M	D	51209		
	Stat Registra	e	31. Date filed (Month	EC 14	2010	32. Regis	trar's Signa	A. A	arks	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:35 P^M Eugene Claudius Harter, Jr. December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lighthouse Senior Living Howard Ellicott City Social Security Number 8. Date of Birth
(Month, Pay, Year)
Aug 11, 1926 9. Birthplace (State or Foreign Country) Brazil If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 1 🛛 M 2 🗆 F Days Yrs. **Director** 291-24-5620 84 Usual Residence of Decedent shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 416 High Street 21620 United States 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. \$ 1 Never Married 2 X Married Yes Yes, Give 2 🗌 No 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates.1944–46 other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Diplomat 5+ Federal Government marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental H ည Harter, Sr. Claudius Maglin Mae Harris and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Dorothy Harter/wife 3020 N. Ridge Road, #314 Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 12/15/2010 Woodbine, Maryland 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Homas uanita M00957 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part \ nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Alzheimers Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ohysician and the burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No signed by the a 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an or Attending Physician: The law prior to completion of cause of death? pade performe 2 No Yes 2 🔀 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital 2 **X**No Assisted-1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Living 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending X Natural work s after death.

I Director: Aft 1 Tes 2 No Accident
Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital 24 hours Funeral Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D47447 December 13, 2010 30. Name and address who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Andy Lagris,

31. Date filed (Me

M.D.

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

Suite 103 Columbia, Maryland 21044

6334 Cedar Lane,

32 Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type or Pri							_			
		For State Registrar			aryland /		artment of I tificate of I	Health and N Death	Mental Hy	giene Reg. N	LUIL	41948		
Physicia Medic			Kenneth	Paul Hugh	es				2. Date of De Decemb		16 2010	3. Time of Death 8:54 P M		
Examin	er			ive street and number) 10rial Hosp:	ital			r Location of Death Frederick		40	4c. County of Death Frederick			
Funeral Director		5. Social Security No.	176	1 X M 2 F							930 Ne	Birthplace (State or Foreign Country) ew York		
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	by	1 Never Marri		d 1 🔀 Yes 2 🗌 If Yes, Give Year or Dates.1	Armed Forces? 1 Si Yes, 2 □ No If Yes, Give Year or Dates. 1953-83 If Yes, specify Cuban, Mexican, P 1 □ Yes 2 No Specify:							White		
within 72 h giene. ier than "na t, the Medic	Completed	(Special Elementary/Second	cify only highest	grade completed)	de completed) (Give kind of work done during mo life. DO NOT use retired)						Kind of Business	d of Business Industry S. Navy		
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Physician/ Medical Examiner	er.	shock, or hear Immediate Cause (I disease or condition resulting in death) Sequentially list con	t failure. List on Final n nditions,	a. Due to (or as	a consequent	enic e of):		, Lung)			Approximate Interval Between Onset and Death		
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	of pregnancy 2 Fetal death t time of death		Ectopic pregnanc Other (specify)	y			23d. Date of de Month	livery Day Year		
quires that the sen signed by the details and be details.	ted by PI	Part II. Other signifi		s contributing to death b	ot not resultin	g in the u	./	ven in Part I				o the cause of death? Probably 4 Unknown		
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ysician s certifi director	To Be	25. Was case referre examiner? 1 \sum Yes 2 \bullet	ed to medical	Hospital:	ent 2 ER/	Outpatien	Oth	er:		dence f	6 Other (Spec	ifv)		
Attending Pher death. ector: After the by the funeral	Certificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending Investiga 6 Could no	t be 28e Place of Inju	y, Year) ury - At home,	Time of injury	28c. Injury work M 1 □	/ at	28d. Describe h	now injur	ry occurred	ral Route Number,		
lospital or I hours aft uneral Dir ed filled in	edical Ce	29a. Certifier 1 (Check 2	Certifying P	hysician: To the best of	my knowledge	e, death o	occured at the time	, date and place, ar	City or Tow	use(s) aı	nd manner as st	ated. cause(s) and manner stated.		
To the H within 24 To the F complete	⋝	only one) 3, 29b. Signature and 1	Certifying N	urse Practioner: To the	best of my kno	wledge, d	eath occurred at the	e time, date and place number	ce, and due to th	e cause((s) and manner as	stated.		
7		30. Name and addre	ess of person wh	o completed cause of d	eath (Item 23a) (Type, P	rint)	65378 7th St	Frank	0511	JK, MD			
(Stat Registra		31. Date filed (Month	n, Day, Year)	7 2010 . 2	ar's Signature	1	barres	1 . 01	1120	_110		oct 101		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend #5 Per FH G911 1/2011 JH
State of Maryland / Department of Health and Mental Hygiene 0 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:08^aM Physician/ 2010 Robert Lee Hofmann. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death District Heights Prince Georges 2213 Breton Drive 8. Date of Birth (Month, Day, Year) 04/03/1951 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 57956840862 **Funeral** 1 🔼 M 2 🗆 F Days Hours Yrs Director 59 578-04-9267 Washington, DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Prince Georges District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22<u>13 Breton Drive</u> USA <u> 20747</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 \(\begin{align*} \begin{align*} \text{Yes} & 2 \quad \text{No} \\ \text{If Yes, Give} & \begin{align*} \begin{align*} \text{1971} & -- \\ \text{If Yes, Give} & \begin{align*} \text{1971} & -- \\ \text{If Yes, Give} & \begin{align*} \text{1971} & -- \\ \text{If Yes, Give} & \begin{align*} \text{1971} & -- \\ \text{197 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1971 Year or Dates. 1972 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Public Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Robert Lee Hofmann, Sr. Shirley Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2213 Breton Drive District Heights, MD 20747 <u> Roberta Knight - Sister</u> 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 Donation 5 Other (Specify) Brentwood, MD Lincoln Cemetery : 12/22/10 Signature of Funeral Service Licenses 22. Name and Address of Facility Ft. Lincoln Funeral Home, Louge Montgomen Cheatkay 3401 Bladensburg Road Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ₹πysiciaπ/ Arteriosele disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of To the Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has b lirector, page 2 s performed 2 🗆 No Yes 2 N 1 Tes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No filled in by the Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 cor

State Registrar 31. Date filed (Month, Day, Year)
DEC 2 2 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Month 2/11 DAVID BERNARD HEARNE SR /2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 3461 REGENCY PARKWAY FORESTVILLE Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Min 13℃ M 2 □ F Months Days Hours Director 2/7/1952 58 578-72-2917 Usual Residence of Decedent " "natural", or items 23a or 28a-f show Medical Examiner must be notified at. 10a, State 10b. County 10c. City. Town or Location Director Maryland Prince George's Forestville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3461 Regency Parkway 20747 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 nand Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12 Government Maintenance Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Linwood L. Hearne Sr. Betha L. Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Sands/ Daughter Sandee 1200 North Capitol Street NW Washington, DC 20002 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/17/2010 | Landover, Maryland Harmony Memorial 21. Signature of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. wha. MOLOST 5538 Marlboro Pike Forestville, Maryland P. 11. Inter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List valv one cause on each line. Immediate Cause (Final Physician/ LIVER METASTASES FROM ANAL CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to Cords a coloses wence of if any, eading to immedia cause. Enter Underlying Cause (Disease or iinjury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): ng physician as the burial Physician/Medical death certificate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown the P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy this certificate 1 ☐ Yes 2**X**☐ No **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 2 🔀 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending in 24 hours after over the Funeral Director: After and after the fur work? 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/16/2010 MD 33109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3800 Reservoir Road NW Washington, DC 20015 Jimmy Hwang

3. Time of Death

0:05

Birthplace (State or Foreign Country)

Washington, DC

Black

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Month

death? 1 ☐ Yes 2 ☐ No

1 X Yes 2 No

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day, Ye DEC 2 2 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 4:20 A M 2010 Carroll Hill Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Crescent Cities Nursing Home Riverdale 5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days onth, Day, 1 🛣 M 2 🗆 F Months Hours Min. 79 DC Director 578-44-0912 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Bethesda MDMontgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 USA 7720 Wisconsin Ave. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 ☐ Divorced **Black** Year or Dates Medical 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Hechingers unknown unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20814 7720 Wisconsin Ave. Bethesda, MD Brett E. Cohen - Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-23-2010 Alexandria, VA Metropolitan Crematory . Signature of Puperal Service Licenses | 22. Name and Address of Facility | Marshall-March Funeral Home of Maryland Suitlnad Rd. Suitland, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. 0 Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death the 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital s after death. Other: 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tyes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check (Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title 00064208 4409 East West Huy, Ruerdale MD 20737 of person who completed cause of death (Item 23a) (Type, Print) M.D

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 10:30 a M Howard Harrison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Marlboro Prince Georges 9705 Grandhaven Ave If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Social Security Number 6, Sex 1 XM 2 D F 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Yrs. Director 424-50-1497 69 04-15-1941 Usual Residence of Decedent 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No GA Stone Mountain Stone Mountain 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 30088 1561 Circle Stone Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 ANo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black. Specify: 3 ☐ Widowed 4 🖾 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Senior Custodian Dekalb County Library 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frankie Mae Howard Louis Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9705 Grandhaven Ave. Upper Marlboro, MD 20772 Felicia Dorsey-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 12-23-2010 | Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 22. Name and Address of Facility Marshall-March Funeral Home of MD 4308 Suitland Rd. Suitland, MD 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Daughter's Hospital 1 Tyes 2 🔀 No Other: မ 4 Nursing Home 5 Residence 6 Nother (Spec 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completed filled in by the funer. 1 Natural
2 Accider
3 Suicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

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29b. Signature and title of e

31. Date filed (Month, Day,

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOVIT

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state

29d. Date signed (N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ December EDNA G. HOLMES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S DOCTORS COMMUNITY HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day) g. Birthplace (State or Foreign 5. Social Security Number 5 7 9 - 3 2 - 28 11 **Funeral** 1 □ M 2 🂢 F 1/6/1932 VÍRGINIA **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No PRINCE GEORGE' LANHAM MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 UNITED STATES 5407 ELLERBIE ST Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Specify: BLACK ☐ Yes 2 🔀 No Specify: 3 Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) DOMESTIC DOMESTIC 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ JAMES JENKINS MALINDA MAHANES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9651 WHITE ACRE RD. COLUMBIA, MD. 21045 GLORIA FIELDS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREM. 12/23/10 BELTSVILLE, 22. Name and Address of Facility CAPITOL MORTUARY r f Funeral Service icense MARYLAND AVE. 20002 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. Lis only one cause on each line. Opset and Death Immediate Cause (Final farction Physician/ disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Lulanow tensoon Sequentially list conditions. Due to for as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending nhysician and To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FÉMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ 1 Live Birth
4 Pregnant a
g Unknown in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) uck Rd, Lanham, md 20706 Date filed (Month, Day, Year) State

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Registrar

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			For State Registrar	State of Maryland	/ Department of Healt Certificate of Dea		/giene Reg. No. 2 A I A I A I A I A I
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	/Medio	and the same of	4a. Facility Name (If not institution, give st		4b. City, Town, or Locat		4c. County of Death
	Examin	EI	Golden Living Cente	er	Hagerstown	n	Washington
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		nder 24 Hrs. 8. Date of B	irth 9. Birthplace (State or Foreign
	Director		219-14-9908	M 2□ F 88	Yrs. World's Days Hot	May 2	
	pu ,		Usual Residence of Decedent 10a, State 10b, County	10c City	Town or Location		10d. Inside City Limits
	aryla shov	-	10a. State 10b. County	Too. Only,	TOWN OF EGGLION		1 ☐ Yes 2 No
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notitled at	Director	MD Washingto	on Ha	gerstown		10g. Citizen of What Country?
	with the		10e. Street and Number		10f. Zip Code		
	s 23; nust	Funeral	17702 Meadowood Dri	IVE 12. Was Decedent Ever in U.S.	21740 13. Was Decedent of Hispani	ic Origin? (Specify Yes or N	U.S.A. 14. Race - American Indian,
	Item Item	Ë	11. Marital Status 1 ☐ Never Married 2 Married	Armed Forces? 1 Maryes 2 □ No	If Yes, specify Cuban, Me	exican, Puerto Rican, etc.)	Black, White, etc.
36	Irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Spe	ecify:	Specify: White
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212	the lieu	E S	9		Contractor		Construction
	be filed htal Hygi od other event, tl	Be	17. Father's Name (First, Middle, Last)		18. N	Mother's Name (First, Middl	e, Maiden Surname)
<u>lar</u>		일	Earl William Hep	pperle, Sr.	l	Mary Needy	
Maryland	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Typ	oe. Print)	19b. Mailing Address (Street and N	lumber or Rural Route Num	ber, City or Town, State, Zip Code)
	5 H O F		Betty Jane Hepper		17702 Meadowood		
Baltimore,	ges 1 an t of Heal If item 2 or other		20a. Method of Disposition 1	cer	ce of Disposition (Name of netery, crematory or other place)	Date	20c. Location - City or Town, State
Ĕ	Par it		4 □ Donation 5 □ Other (Specify)	Res			Hagerstown, Maryland
alt	permit. I Departm Importar any inju		21. Signature of Funeral Service License		22. Name and Address of F	^{Facility} Rest Have	en Funeral Chapel
<u> </u>			* 7 7	2~~	1601 Pennsylv	vania Ave., H	Magerstown, MD 21742
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7	/Medical		disodos of condition				シレスト オオチューダーラン・ハードリングマン
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9			Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant). Due to (or as a conseque	nce of):		23d. Date of delivery
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Records, P.O. Box 6	e law requires that the death certificate be executed has been signed by the attending physician and e.2 should be detached for use as the burial-transit	by Physician/Medical	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque Sc. If yes, outcome pf pregnant Compared to the consequence of dead of the consequence of dead of the consequence of dead of the consequence of dead of the consequence of dead of the consequence of dead of the consequence of dead of the consequence of dead of the consequence	nce of): cy leath 3 Ectopic pregnancy th 5 Other (specify)	Part I. 23e. Dic 1 [24a. Wa au	23d. Date of delivery Month Day Year d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknowr as an lopsy prior to completion of cause of death?
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or Vital Records, P.O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque Consequence of pregnant at time of deal of the consequence of the co	nce of): ruce of): r	Part I. 23e. Did 1 [24a. Wa au pe 1 [Yes Place of Death (Check only	23d. Date of delivery Month Day Year d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown as an topsy rformed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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or Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent) Due to (or as a consequent) 3c. If yes, outcome pf pregnant at time of deady and the pregnant at time of deady at the pregnant at time of deady at the pregnant at time of deady at the pregnant at time of deady at the pregnant at time of deady at the pregnant at time of deady at the pregnant at time of deady at the pregnant at time of deady at the pregnant at time of deady at the pregnant at time of deady at the pregnant at time of deady at the pregnant at time of deady at the pregnant at time of deady at the pregna	nce of): Cy	Part I. 23e. Did 1 [24a. Wa au pe 1 Yes Place of Death (Check only [Wursing Home 5 Re 28d. Describ 2 No 28f. Location City or 7 ate and place, and due to the time.	23d. Date of delivery Month Day Year d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknowr as an lopsy fromed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No y one) sidence 6 Other (Specify) he how injury occurred a (Street and Number or Rural Route Number, own, State) The cause(s) and manner as stated. he, date and place, and due to the cause(s)
Division or Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent) Due to (or as a consequent) 3c. If yes, outcome pf pregnant at time of deady and the consequent at time of the consequent at time of the consequent at time of the consequent at time of deady and the consequent at time of deady at time o	nce of): Cy	Part I. 23e. Did 1 [24a. Wa au pe 1 Yes Place of Death (Check only [Wursing Home 5 Re 28d. Describ 2 No 28f. Location City or 7 ate and place, and due to the time.	23d. Date of delivery Month Day Year d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown as an lopsy fromed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25 No 26 No 27 No 27 No 28 Sidence 6 Other (Specify) 29 No 29 No 20 No 2

State Registrar

31. Date filed (Month, Day, Year)

DEC 2 8 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ForAmend Item 31 State of Maryla State Registrar WCHD/SH 12/28/10 per VR State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2, Physician/ December 20T0 Mildred Sue HUBBARD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 18713 Mary Flowers Lane Hagerstown Washington Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🖾 F July 28 216-44-6279 Virginia Yrs. 1946 **Director** 64 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18713 Mary Flowers Lane 21740 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home <u>Housekeeping</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Claudia Jean Gilliam <u>Morris Herron</u> 19a. Informant's Name/Relationship (Type, Print)
Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 20726 Park Hall Rd., Boonsboro, Maryland 21713 other Gerald W. Hubbard, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot December 28,2010 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemeter, crematory or other place) Cedar Lawn Memorial Park 4 Donation 5 Other (Specify) Hagerstown, Maryland 21. Signa re if Funeral Service Licensee MINNICH FUNERAL HOME 22. Name and Address of Facility 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ to Atherosclorosis and Vents Medical Hypertension Examiner Secuminary list conditions, if any, leading to immediate cause. Enter Underlying Exami sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 Yes 2 No Yes Division of Vital To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? 1 Tes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate; 28c. Injury at Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of high models of death occurred at the line, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioners To the Sest of my knowledge, death 29b. Signature and title of certifier

Registrar

146-2

State

istrar's Signature

owel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item For State Registrar #9, perF.H., 12/17/10, BA Certificate of DeathwCHD Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12/13/2010 2:30 P Holowach Joseph /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Meadow St. Apt. 207 Berlin Year | If Under 24 Hrs. | 8. Date of Birth If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. 10/16/1922 Hours 1**X** M 2 □ F Yrs. PA Director 185-16-1516 Usual Residence of Decedent with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a, State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes - 2 ☐ No Director MD Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21811 USA 1 Meadow St. death v Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1∰Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify Specify: white þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Engineer General Electric Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paraska Chihanska Harry Holowach ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Item 27 I 42 Fort Sumpter South Berlin, MD 21811 Harry Holowach 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 to . Department of Important: If It any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Cemetery 12/21/2010 Roanoke VA
22. Name and Address of Facility The Burbage Funeral Home 4 ☐ Donation 5 ☐ ther (Specify) Fairview Cemetery al Service Licessee 108 William St. Berlin, MD 21811 ulale Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) delicerchang Deeks **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) A391962 Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 1 Yes ₹ 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. within 24 29c, License number 29d. Date signed (Month, Day, Year) ٥

DHMH 17 Rev 1/2001

State Registrar

BA10+1

-1209 Coastal Hy; FERWICK,

address of person who completed cause of death (Item 23a) (Type, Print)

32. Pégistrar's Signature

31. Date filed (Month, Day, Year)
DEC 17 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12-12-2010 Pay Physician/ Shirley Hankin Ann 2:25 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Court Pikesville Arden Nursing Home Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Country) Mary Land Months Days Hours Min. (Month, Day, Year) 78 Director 219-32-3970 11-15-1932 Usual Residence of Decedent items 23a or 28a-f show er must be notified at 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🙀 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 USA 2 High Stepper Court Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. t. Page 1 and 2 should be filed within 72 hours after dy frinent of Health and Mental Hygiene. frant: If item 27 Is marked other than "natural", or i fury or other traumatic event, <u>the Medical Examin</u> 1 ☐ Yes 2 ☐ No If Yes, Give þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🜠 No Specify: Specify: White Completed 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Counselor Health Care Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ George Blickstein Jeanette Ladon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 High Stepper Court #604 Baltimore.Md. Robert M.Hankin -husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Beth El Memorial Park 12-15-2010 Randallstown, Md 22. Name and Address of Facility 21804 Salisbury. Holloway Funeral Home 501 Snow Hill Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementin disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 page 2 s or Attending Physician: The certificate of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Jursing Home 5 Residence 6 Other (Specify) Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After work?
1 Yes 2 No 1 Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MO D0061199 دم 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1105, Touson es 57, Black ha 31. Date filed (Month, Day, Year) 32 Registrar's Signatur park State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Alethia, M, Physician/ Month 12 Harris 2:50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Morphand Medical Center Baltimore Baltimore 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) VA **Funeral** 8 Date of Birth 1 □ M 2X□ F Months Days Hours 4-8-1944 Director 217-42-5845 66 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 807 Mohawk Avenue permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any minury or other traumatic event, the Medical Examiner must once. 21801 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: SpecB:lack Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Charles E. Dozier Ruth Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natalie Dozier/Daughter 703 Morris Street, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Direct Crematory, 12/21/2010 Dover, DE 22. Name and Address of Facility Bennie Smith 917 W. Isabella St. Salisbury, Funeral Home 23a. Part 1. Enter the medase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hoart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final dise or condition resulting in death) Onset and Death Physician/ epsis Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Year 1 Yes 22 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by (ena) disease Coronary artery disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? vascular disease 24a. Was an autopsy performed? Yes 2 No 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signatur and title of rtifier 29d. Date signed (Month, Day, Year) 1093030553 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Quartuccio South Greene Baltimore MO 2120 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rev. John F. Harvey, O.S.F.S. December 1515 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Ceci1 Elkton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Days Hours Min. April 14 Director 214-70-0701 92 Pennsylvania Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director E1kton 1 ☐ Yes 2 X No Maryland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1120 Blue Ball Road 21921 United States 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Specify: Completed White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. Is marked other than life. DO NOT use retired) permit. Page 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other thar any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) <u>Priest/Educator</u> Religion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Patrick J. Harvey Margaret Harkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oblates of St. Francis de Sales 2200 <u>Kentmere Parkway, Wilmington, DE</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oblate Cemetery 2010 Childs, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE Pnysician/ disease or condition Medical resulting in death) Examiner THAB DO MYOLYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exam Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last DMEUMONIA Due to (or as a consequence of): physician at the burial-Physician/Medical P.O. Box 68760 as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 4 ROIDISM 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No Other: မ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident
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DHMH 17 Rev 7/2009

State Registrar M-D

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32 Registrar's Signatur

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month Day, Year)

12/27/2010

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State State Registrar State Registrar	_			1 1	()	1 0	d cause of de		, , , , ,	. ,	•			B.U.					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Scott Albert 2010 11:15 A M Johnson December Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral ^{Year} 19<u>62</u> Hours 1 🛛 M 2 🗌 F Min. Sept 11 New York **Director** 217-86-5257 48 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1832 Tufa Terrace 20904 United States item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner is 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 9 1X Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: African-American Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Flight Attendant Commercial Airline permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lloyd Albert Johnson Gloria Hall D. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lloyd Albert Johnson/father 204 Wedgefield Crossing Savannah, Georgia 31405 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 12/15/2010 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 4somas Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ Cirrhosis of the Liver disease or condition months Medical resulting in death) Due to (or as a consequence of) Examiner Chronic Viral Hepatitis Types B and C years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à HIV/AIDS Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has al director, page 2 autopsy performed? death? Yes 2 No 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 😾No ည Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) Hospice funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending Natural work? 1 ☐ Yes n 24 hours after death. le Funeral Director: A pleted filled in by the fu 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) الحا D37142 December 11, 2010

Registrar

State

Rockville, Maryland 20850

Piccard Drive

Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Mor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles Edward Jones, Jr December 2010 P^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 18345 Lost Knife Circle Gaithersburg Montgomery Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) April 26,1961 1 X M 2 - F Hours Min. Director Maryland 218-88-9022 49 Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at with the Maryland 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20877 18345 Lost Knife Circle United States within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed wir Health and Mental Hygien 'n 27 is marked other th: 'r traumatic evere' Journalist Journalism Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ .. Page 1 and 2 should be tment of Health and Men tant; If Item 27 is marke Charles Edward Jones Sr. Janice Marie Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If Item 27 any injury or other tr Steven M. Jones / Brother 10747 Edgewood Court, New Market, Maryland 21774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc. 12/14/10 Frederick, Maryland. 21. Signature of Funeral Service License 23. Name and Address of Facility Stauffer Funeral Home P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) sclerote Vastulow Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of signed by the attending physician and defected for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Yes g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes ျှ 2 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ature and title of certifier 29d. Date signed (Month, Day, Year) D60417 70 12-13-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Hemen Frederica comas Tohnson DV 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 BRUCE JONES Medical 0914 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death COUNTY GENTERAL HOSFITAL HowaRD OLUMBIA HOWARD Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 🗆 F Months Hours Min. (Month, Day, Yea / 20 / 1960 **Director** 578-80-6691 New Orleans. Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Ft. Washington 1 X Yes 2 □ No 10e. Street and Number ms 23a or ò 10f. Zip Code 10g. Citizen of What Country? Funeral 6916 Noah Dr. 20744 United States Page 1 and 2 should be filed within 72 hours after death vment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 Married 9 Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Materials Handler Mobern Lighting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cornelius Jones, Jr. Joann Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Marie Jones / Wife 6916 Noah Dr. Ft. Washington, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/29/2010 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Memorial Landover, Md. 21. Signature of Funeral Service Licent 22. Name and Address of Facility Alexander S. Pope 5538 Mariboro Pikė/ Pfa. Forestville, Md. 20747 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ ARTERIOSC LEROTIC CARDIOVACCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner INFARCTION MYOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last buria physician s the burial Physician/Medical Box 68760 as ading IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Į. in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year Yes 2 No the 9 Unknown 9 Unknown P.O. | signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 1 Yes 2 No Yes 200 No or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 1 Alpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of After t 28d. Describe how injury occurred Natural 5 Pending injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотретес Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) D50377 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 ERLINE, NO MICHAEL CEDAR LN COLUMBIA MO 21044 32. Registrar's Signature 31. Date filed (Month. State

Registrar

DEC 2 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $12^{\text{Month}} - 2010^{\text{ay}}$ 8:45P REUBENA E. JARRETT М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S SPRINGBROOK ADVENTIST NURSING HOME HYATTSVILLE 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours SEPT. DE 3 ear) 1919 JAMAYCA 91 Director 577-82-3543 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ¥ Yes 2 □ No PRINCE GEORGE'S HYATTSVILLE MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral USA. 20147 PETTERSON RD 20782 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces?
1 ☐ Yes 2 🔼 No Black White etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) COOK PRIVATE 12th other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o ပ ELIZABETH JARRETT CAREY MCKENZIE permit. Page 1 and 2 should be Dapartment of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUNRISE DR LANHAM, MD 20706 MARIE GAYLE/GRANDDAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place)
GATE OF HEAVEN 1 KBurial 2 Cremation 3 Removal from State 12-23-2010 SILVER SPRING, MD 4 ☐ Donation 5 ☐ Other (Specify) JE JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ yrs brovascu disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit that the death certificate be executed APPROVED BY MEDICAL Due to (or as a consequence of): resulting in death) Last CERTIFICATIO Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vegetative 2 No 3 Probably 4 Unknown The law requires 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No to Cerebrovascular Disease 24a Was an autopsy performed? Yes 2 has Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Yes -2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Investigation 6 Could not be Accident
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 1 Medical Examiner: On the basis of examination and/or investigation, in my officing the state and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated as Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) D31001 20/2010 MD 30. Name and address of person who complete duse of death (Item 23a) (Type, Print)
STUART TURKEWITZ MD 7500 GREENWAY CENTER DR SUITE 430 GREENBELT, MD 20770 Date filed (Month, Day, 32. Registrar's Signature State DEC 2 3 2010 ark Registrar

State of Maryland / Department of Health and Mental Hygiene U 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 058 M **Physician** 2010 George Earl Jarkey /Medical 4b. Çity, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Hageistour utheran 111090 Karenwood 6. Sex 1 M M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number **Funeral** Vear Hours Months Days 546-28-8570 5,1920 90 Feb. Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventual or out he multiple and once. 1 ☐ Yes 2 No Maryland Washington County Hagerstown Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13536 Cherry Tree Circle 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 X Yes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Configuration Management Aerospace Industry 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ George F. Jarkey Ruth Suzanne Hackett Jarkey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Phyllis A. Jarkey-wife <u> 13536 Cherry Tree Circle Hagerstown, MD 21742</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 12-28-2010 | Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Suprature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 114 eaus **Physician** disease or condition resulting in death) /Medical Due to (fr as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician a Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has the rector, page 2 sl autopsy 2 1No 1 ☐ Yes 25. Was case referred to edical examiner? 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 H Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28b. Time of 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending n 24 hours after death.

Reference Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mill Street At agerstonn 21740 5H- St1 R State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Ve Day Year Medical 5:35 **Examiner** 4b. City, Town, or Location of Death County of Death ince **Funeral** 1 1 M 2 | F If/Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Director 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral 10g. Citizen of What Country? 12. Was Decedent Ever Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. If Yes, Give Year or Dates To Be Completed 3 Divorced 1 Yes 2 110 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Bunal 2 Cremation 3 Removal from State Date 4 Donation 5 Other (Specify) Signature of Funeral/Ser 22. Name and Address of Facility 2000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CARDION Collapse Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner resulting in death) Last by the attending physiciar To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 onchogeni Month IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Kidney Completed 1 🗆 Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 25. Was case referred to medical examiner?

1 Yes 2 No 2 No To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12,50 Annapoly Road Svile 200 Glenn 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ December 27. Ruth Jones Naomi 2010 06:30am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. Country) 95 Kansas **Director** 510-09-4930 Sept. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director VA Fairfax Reston 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11311 Fieldstone Lane 20191 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates item 27 is marked other than "natural", other traumatic event, the Medical Exar White Specify: Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Librarian School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ည Emma W. Young Leslie W. Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Douglas P. Jones - Son 11311 Fieldstone Lane Reston, VA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Adams-Green Funeral Home Herndon, VA 4 ☐ Donation 5 ☐ Other (Specify) 721 Elden St. 21. Signature of Funeral Service License 22. Name and Address of Facility Adams-Green Funeral Home Herndon, VA 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ neumon disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 No ed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📆 No 3 ☐ Probably 4 ☐ Unknown carlore Were autopsy findings available prior to completion of cause of death? 24a. Was an roni has autopsy page perform certificate I 1 Yes 2 No Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🗡 Natural 5 Pending injury 24 hours after death, Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 **To the I** 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title MID DO05061) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 MALIER mp MUEL 31. Date filed (Month, Day, Year) Registrar's Signa State JAN 05 Registrar

6 DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ De**cemb**er 2010 5 Ruth Bopp Kellermann Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard 10152 Hobsons Choice Lane Ellicott City If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🔀 F Hours Min. Feb 16 Pay, 81 MD Director 214-26-0153 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at **Funeral Director** 1 🗌 Yes 2 🄀 No MD Howard Ellicott City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 101<u>52 Hobsons Choice Lane</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) 2 should be filed with th and Mental Hygien 7 is marked other th 12 Homemaker own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Edward A. Bopp Cora M. Coggins 19a. Informant's Name/Relationship (Type, Print Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 st ment of Health a ant: If item 27 is John L. Kellermann, Jr. 10152 Hobsons Choice La. Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ₩ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/20/10 Woodlawn, Maryland Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of FacilitHarry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ 1900 disease or condition HUDOM SUC Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 / the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 📉 No Day Pregnant at time of death 9 Unknown ģ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be det þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?. Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat d title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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Registrar

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>010</u> Physician/ Month 12 <u>a</u> ^M Robert Paul Kilpatrick, Sr. 13 0104 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 6. Sex 1 ፟ M 2 ☐ F 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year 02 09 1 Director 65 1945 258-70-1691 Usual Residence of Decedent or 28a-f show notified at should be filed within 72 hours after death with the Maryland and Mertal Hygiene. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be Funeral 4528 6th Place NE 20017 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chief EEO Federal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ permit. Page 1 and 2 should be Department of Health and Mortant: If item 27 is market any injury or other trainmatic. Delander Kilpatrick Julia Ann Spradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary W. Kilpatrick/ Wife 4528 6th Place NE Washington, DC 20017 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 12/17/2010 Brentwood, MD 4 Donation 5 Other (Specify) Lincoln Cemetery 22. Name and Address of Facility Ft. Lincoln Funeral Home Signature of Fun ral Service Licensee 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atter should be detached for a in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Chronic Kidney Disease autopsy performed? Yes 2 A No has 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 🗌 Yes 2 X No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064624 12/16/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sardeep Sharma, 1500 Forest Glen Rd. Silver Spring, MD 20910 32. Registrar's Signature State Registrar

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Division of Vital Records,	in or Autending Prifysician; the is after death. Director; After this certificate had in by the funeral director, page	Certificate:	3 ☐ Suicide 4 ☐ Homicide		28e. Place of Inju			street, factory, office	1 Yes 2 N Needent of Hispanic Origin? (Specity Yes or No- pedify Cuban, Mexican, Puerto Flican, etc.) 14. Race - American Indian, Black, White, etc.	ral Route Number,				
:	To the hospital of Actionaling Physician; The law requires that the death certificate within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L	Medical Exam	yiner: On the basis of ex	amination	and/or inv	estigation, in my opi	nion, death occurred	d at the time, date a	and place	e, and due to the	cause(s) and manner stated.	
	Within Comp		only one) 3 L 29b. Signature and tit		1 Tablioner. To the	reat Of IIIy	Kilowieug			nace, and due to th		-		
	ī				1/1-	_		103	538	f	1	3/8	7	
	'su				completed cause of de			e, Print)		-	- {		1	
	V		Williay Bate filed (Month)		INS UD		200	Civic	, Ave	SALi	Sb	URY, Me	121804	
	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Elizabeth Ligon DIPMBE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Doctor Community Hospital Lanham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 21 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Year) 920 Months Days Hours Director North Carolina 578-32-0350 90 Oct. Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1402 Nye Street 20743 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc.
African þ 1 Never Married 2 Married $\sum g$ $g \mathcal{M}$ // $\mathcal{M} \mathcal{M}$ Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: "natural", 3 🛮 Widowed 4 🗌 Divorced Completed Year or Dates American event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mea life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Civil Servant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Otho V. Carpenter Betty Candice Everette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20740 5006 Pierce Avenue College Park, Md. Dennis T. Ligon Jr. - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 23, 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signature of Funeral Cervice Licence 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death 1570/ic Ph_sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner signed by the attending physician and dedetached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an After this certificate has autopsy performed Yes 2 death? 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Sulcide
4 Homicide Investigation 24 hours after deat Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6000

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DÉCÉMBER SHIRLEY LEWIS 11:15A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 KF (Month Day, une 15, Days Hours Virginia 86 June **Director** 577-60-2480 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 □ No D.C. None Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5439 Sherrier Place NW 20016 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced White "natural" Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant: If item 27 is marked other than 'ury or other traumatic event, the Me College (1-4 or 5+) Tax Law Specialist IRS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carrie McClanahan Thomas H. Bern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1931 Keysville Rd. South Keymar, MD 21757 Mildred Weaver Sister 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If any injury or once, 4 Donation 5 Other (Specify) National Memorial Park 12/16/2010 Falls Church, Virginia 22. Name and Address of Facility Murphy Funeral Home 21. Signatus and ral Service Licensee 1102 W. Broad St. Falls Church, VA 22046 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, healing to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to lor as a consequence of or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 1 Yes Z should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed 1 ☐ Yes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown peen s Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ပ 1 Yes 2 AH6 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Sulcide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Defitying hystochambers: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated . 29b. Signat are and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60417 12-12-10 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick 21702 Tohnson shah Momas emen C 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12 15 2018 09:44 AM Robert Leuschner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 11771 Mardela Sharptown Rd. Mardela Springs 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 □ 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 09118 11927 83 Maryland 218-22-9223 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Mardela Springs Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21837 11771 Mardela Sharptown Rd. USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 ★ Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the ! Security Security Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Amelia Johnson Benjamin Leuschner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 11771 Mardela Sharptown Rd., Mardela Springs, MD2183 <u>Cinthia Majors Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12 16 2010 Salisbury, Maryland Salisbury Crematory 21. Signature of Funeral Service Licensee 22.Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd.,Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lijne. Approximate Interval Between Onset and Death Physiciani disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an after death.

Director: After this certificate has autonsy page 1 Yes 2 No Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2. No 1 🗌 Yes Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 29c. License number 10050614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State ULL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ LOIS MAE MORELAND 12 14 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY 613 FREDERICK STREET CUMBERLAND Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Months 09/13/195 **Director** 215-58-6390 50 MARVT AND Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland ral", or items 23a or 28a-f shorexaminer must be notified at Director MD ALLEGANY CUMBERLAND 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 613 FREDERICK STREET 21502 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: WHITE Completed 3 ₩ Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megonee. other than Elementary/Seconday (0-12) College (1-4 or 5+) **HOMEMAKER** HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 6 (UNKNOWN) PEARL GORDON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID L. EASTON / SON 1767 RIVER ROAD, SALISBURY, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Meml. Park: 12/16/2010 CUMBERLAND, MD 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 21. Signature of Funeral Service Licensee 202 GREENE STREET, CUMBERLAND, MD an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediata Cause (Final disease or condition resulting in death) Physician/ Mitastati Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 24 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2.0 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending nours after death. neral Director: Af I filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town. State) within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or ipvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number \mathcal{D}_{337} 29b. Signature ary 29d. Date signed (Month, Day, Year) 12/14/2010

n des State

Registrar

DHMH 17 Rev 7/2009

12502 Willowbrook Road, Cumberland, MD

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Qamar Zaman, M.D.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Pauline Harriett McKenzie 2:25 am /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Lions Care Center Cumberland 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Xgar) March 08, 1920 5. Social Security Number **Funeral** Days Min 216-22-6691 1 ☐ M 2 🗷 F Perinsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location ortant; if item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, its Modical Evanture must be notified at Corriganville Maryland Allegany 1 ☐Yes 2 XNo Director 12902 N. W. St. George Lane 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. death with 21545-Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: White \$ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r O College (1-4or 5+) Elememary/Secondary (0-12) social veteran's club bartender 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Cecil Leon Long Be (Nora Mae Sturtz ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12902 N.W. St. Georges Lane Corriganville Maryland 21524-19a. Informant's Name/Relationship (Type. Print) Cherie De Haven da daughter Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Patrick's Catholic Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 ■ Burial 2 □ Cremation 3 □ Removal from State Mt. Savage Maryland December 27, 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 marthi **Physician** Severe Û /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): ed by the attending physician detached for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed? Yes 2 2 0 certificate 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖼 🗓 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this Date of Injury (Month, Day, Year) 28b. Time of Injury ne Hospital or Attending Pl 24 hours after death. The Funeral Director; After the 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hor To the Fune completely fi (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dec 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland MD21502 12 Bis O 32. Registrar's Signature State Registrar

			. For	State of Marylan						1 11978		
		_	_ State Registrar		Cer	tificate of L	Death		Reg. No.	0 91010		
	Physicia Medic		1. Decedent's Name (First, Middle, Last, LENA MC	GEE				2. Date of Dea	Day 20/	3. Time of Death		
	Examir	er	4a. Facility Name (if not institution, give s		Inc D		r Location of Deatl	,	4c. County of D			
and the	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. la	ast birthday)	TAKOM If Under 1 Year	If Under 24 Hrs	8. Date of Birt	MONTG	Birthplace (State or Foreign		
	Director		Z18-16-4707 1 Dusual Residence of Decedent	M2 MF 91	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 1919	Country) PA		
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County FL PINELL		y, Town or Loc ARGO	ation				10d. Inside City Limits		
	the Ma or 28¢ e notif	Dire	10e, Street and Number		-11100	10f. Zip Code			10g. Citizen of What			
	s 23a nust b	eral	11182 137th	STREET		337	74		USA			
	death r item iner n		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	oecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.		
036	safter ral", o Exam	ed by	3 M Widowed 4 Divorced	1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates.	1	☐ Yes 2 🗷 No	Specify:		Specify: 🕨	unite		
5-0	2 hour "natu edical	plet	15. Decedent's Ed (Specify only highest grad		16a. Deced	ent's Usual Occup	ation during most of wo	rking	16b. Kind of Busine	ss Industry		
21215-0036	ithin 7 ene. r than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		NOT use retired)			own H	fome		
nd 2	filed wall Hygi	Be	17. Father's Name (First, Middle, Last)	-: (C				me (First, Middle,	Maiden Sumame)			
Maryland	uld be file Mental narked c	은	Millard G.	Shaffer			Kate	Λ.	Reese			
Mai	2 shour the and 27 is m		19a. Informant's Name/Relationship (Ty); Kate L. Risgs	pe, Print) / DG/H	19b. Mailin			LARGO	r, City or Town, State, FL 33	Zip Code) 5774		
re,			20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of patory or other place	1	Date	20c. Location - City	or Town, State		
Baltimore,	Page 1 ment of tant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	IMMOV	V CEMET	ERY 12-	27-2010	HYNDMA	N PA		
Balt	permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr		21. Signature of Funeral Service License				ss of Facility HAI			cral Home INC 15545		
	Physician/		23a. Part I. Enter the disease, or compl shock, or heart failure. List only on Immediate Cause (Final	lications that caused the deatle cause on each line.	h. Do not ente	r the mode of dyin	g, such as cardiad	or respiratory ar	rest,	Approximate Interval Between Onset and Death		
	Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ	uence of):	MEINON	nage					
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	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c								
_	be executed sician and burial-transii	cal E	resulting in death) Last Due to (or as a consequence of):									
68760			IS SELVIN S	d								
39 ×	eath certificate k attending physi I for use as the l	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 Live Birth 2 Feta	Ideath 3	Ectopic pregnand	су		23d. Date of Month	delivery Day Year		
Box	re dear the arched for	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of c 9 ☐ Unknown	death 5∟	Other (specify)			Worth	Day Tour		
P.O.	es that the des signed by the s I be detached I			Part II. Other significant conditions con HEDENTEN SION	ntributing to death but not res	ulting in the u	nderlying cause gi	ven in Part I.			e to the cause of death? Probably 4 Unknown	
rds	require been si should	eted	119101121011					24a, Was		autopsy findings available		
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alF	ician: The law certificate has rector, page 2	Be C	25. Was case referred to medical examiner?				ace of Death (Che		2 110	ico Zano		
f Vii	Physicia this cert	မ	1 ☐ Yes 2 ☐ No 27. Manner of Death	lospital: 1 Inpatient 2 28a. Date of injury	ER/Outpatien	t 3 DOA Oth	4 ☐ Nursing I		dence 6 Other (Sp	pecify)		
o uc	nding l ath. :: After e funer	cate	1. Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work		Zod. Describe i	now injury occurred			
Division of Vital Records,	il or Attendii after death. Director: Al d in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		et, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,		
Ω	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical (ician: To the best of my knowl								
	To the H within 24 To the Fl complete	_	only one) 3 Certifying Nurse	Practioner: To the best of my	knowledge, o	eath occurred at th	e time, date and pl	ace, and due to th	e cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)			
•	5.≥58		29b. Signature and tiple of certifier			29c. Licenso	064024	,	/2/23/2	010		
	Soll	29d. Signature and type of certifier 29d. Date 29d. License number 29d. Date 29d. D								E MD ZOGIZ		
	<i>III</i> (3∞) Sta	te	31. Date filed (Menth, Day, Year)	32. Registrar's Signat	ture			INKOM	MIMICE	1110 60116		
	Registr	ar 2010 Anni p. Anni										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 9:30 ам 2010 Marjorie Theresa Morris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Upper Marlboro 3601 Eton Way 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🕱 F Months Hours Min 04-24-1932 Vandergrift,PA Director 78 054-26-1081 ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 □ No Prince George's MD Glenarden 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7954 Dellwood 20706 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No
If Yes, Give
Year or Dates. ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced er than "natur the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Data Entry Operator Private 12 other of the and Mental Hygie 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Maconi Rosella George King it. Page 1 and 2 should be riment of Health and Me riant. If item 27 is mark njury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) β601 Eton Way Upper Marlboro MD 20772 <u>Tonya M Williams-Mayo/Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery: 12-27-2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of FacilityFort Lincoln Funeral Home 21. Signature of Funeral Service License 3401 Bladensburg Rd Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death **hour** shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Acute myocardial infection Medical Due to (or as a consequence of): Examiner 10 years Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Tetal death ξ in the past 12 months?
1 ☐ Yes 2 🖾 No Month 5 Other (specify) Dav Year Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed ģ page 2 should be Diabetes Mellitus 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension has performed certificate Yes 2 K No 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughter's Other: 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 🛚 Natural 5 Pending 2 🗌 No 1 🗌 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29c. License number 29b. Signatu 29d. Date signed (Month, Day, Year) ٩ D0016410 12/21/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2116 Good Luck Road Gabriel Jaffe,MD Lanham,MD 20706

Registrar

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Cartificate of Bastle . Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Physician/ Jesse J. McKnight 2010 0036 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital <u>Silver</u> Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 23 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours NC 1 ₹ M 2 🗆 F Director 68 244-64-650 show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Temple Hills MD PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a or Examiner must be Funeral United States 4210 24th Avenue 20748 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 🔽 Never Married 2 🗌 Married 1 Yes 2 No If Yes, Give Year or Dates. þ Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🙀 No Specify 27 is marked other than "natural", traumatic event, the Medical Exal Completed 3 Widowed 4 Divorced Rl Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed <u>Entrepreneur</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie L. Gidney G. McKnight Jesse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

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19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 so that of Health at the infinem 27 i Karishna McKnight/daughter injury or other Baltimore, 20a. Method of Disposition 20c. Lagrandia Company State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Lincoln Mem. Cemetery 12/20/10 \mathbf{r} Suitland, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. of Funeral Service Licensee Signatur 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Par 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 2 No certificate Yes Physician: Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, (YA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Forest Glen Rd., Silver Nequi

State Registrar . Date filed (Month, Day,

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			for State Registrar						ate of L				Reg. N	E-100 100 1	J				
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Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or othe		20a. Method of Dis 1 TBurial 2		Removal from St	ate	Place of Dispo cemetery, cren	natory o	r other plac		Date			ocation - C	-				
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Ba	permit Depar Impor any in once.		21. Signature of Fu	ineral Service Licer	isee					ss of Facility OVER RO						ND 20785			
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Division of Vital Records,	: The law icate has r, page 2 s	Completed by									_	autop perfor 1 🗌 Yes	SV	pri	or to cor ath? Yes	npletion of cause of			
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	n 24 hou n 24 hou ne Funer	Medical	(Check 2	Medical Exam	rsician: To the best iner: On the basis of se Practioner: To t	of examination	n and/or invest	igation, i	n my opinio	n, death occurr	red at the tin	ne, date ar	nd place	, and due to	o the cau	se(s) and manner stated			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death / Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Beath Examiner TON If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Funeral Day, Year) 1959 1 M 2 N P 51 Months Davs Hours Min. California Director 552-29-7390 ems 23a or 28a-f show r must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State **Funeral Director** 1XX Yes 2 ☐ No Maryland Prince Georges Cheltenham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10402 Basel Drive filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Black, White, etc. 5 1 Never Married 2 X Married Completed by 2 No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 Divorced traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th. Office Manager Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental ဂ္ဂ Anna Ormand Erin Lee McGlothlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10402 Basel Drive, Cheltenham, Maryland 20623 Gregor Moody/ Husband 20a. Method of Disposition
1 ☐ Burial 2 Å Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o 4 Donation 5 Other (Specify) 17, 2010 Waldorf, Maryland Crematory Dec 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Retween Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a complete fillied in by the funeral director, page 2 should be detached in a \ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) To Be examiner? Hospital Other: 1 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 | Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) nden Date filed (Mo State

DHMH 17 Rev 7/2009

Registrar

10-09923

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Juanita Moxley State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Deat Medical Examiner Month 0310 hrs <u>Juanita Joy MOXLEY</u> December 24, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 430-03-4703 1 M 2 X F 90 Yrs May 23 1920 Country)Arkansas Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington 1 Yes 2 X No hours after death with the Maryland Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6505 Virginia Avenue 21795 USA Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? 1 Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify. Š White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Pages I and 2 should be filed within 72 h nent of Health and Mental Hygene.
ant: If item 27 is marked other than "n or other traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Homemaker <u>Her own home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Hugh Johnston Ruth Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh Talton - Son Old National Pike, Hagerstown, Maryland 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify Hagerstown Crematory 12/27/10 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home Wilson Blvd. Hagerstown, Md. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical veen Onset and a. Subdural Hematoma Immediate Cause (Final disease Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical physician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Day Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown red by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hypertensive Atherosclerotic Cardiovascular Disease 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? Yes 2 ✔ No death? this certificate Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Dec 6, 2010 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1125 hrs Subject fell death 5 Pending the 1 Yes 2 ✔ No 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 28f. Location (Street and Number or Rural Route Number, City 6 Could not be within 24 hours a To the Funeral I determined or Town, State) 141 S. Main Street, Boonsboro, MD (Specify) Nursing Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 24, 2010 OCME 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner Mary G. Ripple/MD. 111 Penn Street, Baltimore, MD 21201

NSH-17-

32. Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Cletus Robert Mever /Medical 4a, Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Village tage T If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 511-16-2236 89 Director 4/25/1921 <u>Kansas</u> Usual Residence of Decedent 10a, State 10b. County ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it is Audical Examinat nust to indified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1109 Luther Drive Funeral 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No ģ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Lighting Consultant 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental and Mental Joseph Meyer ပ Dittoe Cora 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any injury or other trau once. Joseph Meyer / Son 8297 Morningstar Lane, Waynesboro, PA 17268 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 12/24/2010 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tare of Funeral Service Licen 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nem oma disease or condition resulting in death) 24 hour /Medical Due to (or as a consequence of): Examiner 34ears Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) certificate has been signed by the irector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 1 No 1 ☐ Yes 24 No 24 hours after death. e Funeral Director: After this certific letely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1/Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one)

5H-0-1 State

To the within 2

Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

2 A-R

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

19

32. egistrar's Signature

368

nelle

29c. License number

Heigestam

29d. Date signed (Month, Day, Year) 12-22-10

State Registrar

: 5H-1

STEVEN BLASH, MD

31. Date filed (Month, Day, Year)

DEC 27 2010

Suit 204 Hagerstown MD

12916 Conamar Dr

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 7 2010 Physician/ LAURA MICHAEL 8:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 7924 ECHOLS AVENUE GLENARDEN 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Days Hours AUG 31 VÍRGÍNIA 231-30-7820 93 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at Director 1 √2 Yes 2 ☐ No MD PRINCE GEORGE'S GLENARDEN 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ō Funeral items 23a 7924 ECHOLS AVENUE 20706 USA within 72 hours after death . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. rmed Forces:

Yes 2 No Ь þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No Specify. If Yes, Give "natural", 3 XWidowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE PRIVATE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည JOHN THOMAS PAGE ANNIE FARROW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARNEY P. MICHAEL/SON ECHOLS AVENUE GLENARDEN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Bernoval from State 4 Donation 5 Other (Specify) 12/20/2010 CHELTENHAM MARYLAND VETERANS CEME 21. Signature of Funeral Servi 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ CHRONIC RENAL FAILURE Medical resulting in death) Medicai ر Examiner Due to (or as a consequence of) HYPERTENSION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to for as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 🛶 No 2 Ty No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 2 To the F

State Registrar (Check

only one)

29b. Signature and title of

31. Date filed (Month, Day, Year)

DEC 2 1

2 L 3 L

KADIE LEACH M.D.

2010

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) DECEMBER 10, 2010

20706

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

9500 ANNAPOLIS ROAD # A-1 LANHAM, MARYLAND

29c. License number

D27521

Please Type or Print in Black In	idelible ink. Ensure All Copies Are Legible.	98
State of Maryland / Depa	artment of Health and Mental Hygiene	-

	1- For State Registrar	Certificate of Death	Reg. No.						
Physician/	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year 33.45 hrs.						
cal Examine	beatifice b.	<u>Mettle</u>	December 19, 2010 2345 nrs						
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death							
	6304 Ayshire Drive	(In yrs. last birthday) If Under 1 Year If Under 24Hrs	Wicomico						
Funeral Director		Foreign							
Director	217-76-4716 1 M 2 X F	61 Yrs.	3-23-1949 Country Ghana						
à	Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town or Location	10d. Inside City Lin	mits					
0			1 Yes 2 X	No					
to to	MD Wicomico 10e. Street and Number	Salisbury [10] Zip Code	10g. Citizen of What Country?	_					
th the Maryland 23s or 28s-f sho notified at once.									
hours after death with the Maryland matural?, or items 23s or 28s-fab Examiner must be notified at once ed by Furneral Director	6304 Ayshire Drive	ver in U.S. 13. Was Decedent of Hispanic Origin? (Sp	USA pecify Yes or No- 14. Race - American Indian, Black,						
eath vitem	1 Never Married 2 Married Armed Forces?_	If Yes, specify Cuban, Mexican, Puerto							
her de	1 Yes 2 X 3 X Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specify: Black						
urs aft ntural" amine	15. Decedent's Education (Specify only highest grade comp	leted) 16a. Decedent's Usual Occupation (Give kind of							
2 3 3	Elementary/Secondary (0-12) College (1-4 or 5+	during most of working life. DO NOT use reti	red)						
5-0036 led within 72 Hygiene, other than " the Medical	10	Custodian	Wicomico County Sch	001					
			(First, Middle, Maiden Surname)						
2121 ould be fill Mental I marked ic event,		Akwei Funny	Obushie						
O % B .= E	19a. Informant's Name/Relationship (Type, Print)		Rural Route Number, City or Town, State, Zip Code) 191.	39					
	Samuel Akwei - Brother 20a. Method of Disposition	5819 Arch Street, Phil	Ladelphia, Pennsylvania Date 120c. Location - City or Town, State						
Baltimore, permit. Pages lar Department of Herimontant: If ite mignerant: of the mignary or other transity or other transity or other transity.	1 Burial 2 X Cremation 3 Removal from State		200. Education - Only of Towns, class						
Page Page ment the proof or of	4 Donation 5 Other Specify:	Creamtory of Delmarva 12-	-22-2010 Delmar, Delaware						
Baltimo permit. Page Department o Important: injury or oth	Sig ure of Funeral Service Licensee	22. Name and Address of Facility	Bounds Funeral Home						
	I lens helly twolin		Salisbury, Maryland 21804						
Physician /Medical	23a. Part I. Enter the disease, or come is tions that caused the failure. List only one cause on each line.		Between Onset a						
Examiner		ive Atherosclerotic Cardio	vascular Disease Death						
,	or condition resulting in death) Due to (or as a conseq	uence of):							
a	Sequentially list conditions, if any, leading to immediate Due to (or as a conseq.	uence of):		_					
red Insit	cause. Enter Underlying Cause (Disease or injury that initiated								
Exa st	events resulting in death) Last Due to (or as a conseq	uence of):							
	d. MUNPENDED AMENDED 23	a,pt.II,27,28a-f per me g9	11 1-25-11 vt						
760, cate be execut physician and the burial - tra									
B760, ificate be ug physic as the burn	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome 1 Live birth	of pregnancy 2 Fetal death 3 Ectopic pregna	23d. Date of delivery ncy Month Day Year						
Box 68° e death certificate attending ed for use as hysician	past 12 months? 4 Pregnant at tir								
). Box 68' the death certification by the attending tiched for use as Physician	1 Yes 2 No 9 Unknown 9 Unknown								
			23e. Did tobacco use contribute to the cause of death?						
ires that is signed if be deta	Hypothermia due to Envir	onmental Cold Exposure	1 Yes 2 No 3 Probably 4 Unknow	۸n					
ords, F v requires s been sign should be			24a. Was an autopsy findings availa prior to completion of cause						
Records, I The law requires frate has been signate, page 2 should be Completed			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	,					
ion of Vital Records, tending Physician: The law requireath. Ior. After this certificate has been si the funeral director, page 2 should bation: To Be Completed	25. Was case referred to medical	26.Place of Death (Check							
F Vital Physician r this cert ral director	examiner? 1 • Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient 3 DOA Other4 Nursin	g Home 5 Residence 6 ✔ Other: Scene						
n of Vital I ding Physician: h. After this certifi funeral director, on: To Be C	27. Manner of Death 28a. Date of Injury (Month, Day, Yea	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred						
on the fu	Natural 5 Pending Fd 12-19		subject within unheated ho	use					
Division tal or Attending as after death. al Director: Aled in by the file or by		ry - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number of Rural Route Number, (or Jown, State) 6304 Ayshire Dr.	City					
Division o apital or Attending tours after death. Beral Director: After filled in by the function: Certification:	4 Homicide determined (Specify)	residence	Salisbury, Md. 21801						
Hos 24 ho Fun etely in	(Oncar any	knowledge, death occurred at the time, date and place, and	• •						
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: completely filled in by the filledial Certification	One) 2 Medical Examiner: On the basis of examinand manner stated.	nation and/or investigation, in my opinion, death occurred a	t the time, date and place, and due to the cause(s)						
r » r »	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
	11/16	(A) O.C.M.E.	December 20, 2010						
	30. Name and address of person who completed cause of dea	•							
	Russell Alexander MD. Assistant Medical		D 21201						
	31. Date filed (Month, Day, Year) 32 Registrar's	Signature Saule							
Registrar	Eli 21 2010 Consum	1. Marian	OCME						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kathryn A. Morrison M 2 14 2010 Medical 22:06 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗶 F Hours Min. 0112211919 MaryTand Director Yrs 215-18-4369 91 Usual Residence of Deceden 28a-f shov 10a. State 10b. County death with the Maryland must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Delmar 1 Tes 2X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21875 USA 30445 Danwood Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Midowed 4 □ Divorced "natural" Specify: White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Domestic traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental fitem 27 is marked ပ Laurence Adkins Amy Dolby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13419 Princedale Dr., Woodbridge, VA 22193 Stuart Morrison 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1.8
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 12/17/2010 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 22. Name and Address of Facility Holloway Funeral Home P.A.21. Signature of Fuperal Service Licenses Snow Hill Rd. Salisbury, Maryland 21804 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) AGUTE MYDOARDIAL Medical Due to (or as a consequence of): Examiner AFRERO SCIEROTIC DISEASE HEART Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last YEARS Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA OF AccheINERS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 Shot 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 K No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 → No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

RONALD

31. Date filed (Month, Day, Year)

MUD

RAVITZ

32. Registrar's Signature

Carecara.

036576

RIVERSIDE DR

and address of person who completed cause of death (Item 23a) (Type, Print) 1665 Wood BROOKE DR SALISTOURY MD

arks

560

12/16/2010

SALISBURY MO 21807

ZIBOY AND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death p Physician/ Month JOHN LEONARD MATTHEWS Decombee 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisba Vicomico ninsula Regional Medical Conte 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Months Hours 222-14-3147 83 Director DELAWARE Usual Residence of Decedent 23a or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director DELAWARE SUSSEX DELMAR 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral AMERICA 35719 MT HERMAN CIRCLE 19940 is marked other than "natural", or items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Black, White, etc. 11. Marital Status Armed Forces?
1

Yes 2 □ No 1 Never Married 2 Married δ 1 ☐ Yes 2 XNo Specify: Specif WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) CONSTRUCTION College (1-4 or 5+) CARPENTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LAURA BELLE JOHNSON JOHN WALTER MATTHEWS 193 Maijing Address Fitneet and Number or Rural Route Number, City or Town, State, Zip Code)
HERMAN CIRCLE 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is PATRICIA M. MATTHEWS DELMAR, DELAWARE 19940 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CREMATORY OF 1 \square Burial 2X Cremation 3 \square Removal from State any injury or 12/19/10 DELMAR, DELAWARE 4 Donation 5 Donation 21. Signature of Fune al Service Licensee 2WATSON-YATES FUNERAL, HOME, INC. STREETS SEAFORD, KING Rart 1. Ento the disease, or complica shock, or heart failure. List only one complications of the complete shock of the complete sho hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Care disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the Inneral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ᅙ 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1. Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Praction of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAPERI SALISBURY ma MD 100E CARROLL 31. Date filed (Month, Day, Year) 32 Registrar's Signature State parke Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Leon Brickous McIntosh 1030 10 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional Poninsula Madicul Conte OMI If Under If Unde 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ▼ M 2 □ F Months Davs Hours Min. (Month. Country) Director 42 27-1967 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Somerset MD Princess Anne 23a or 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30101 Kristwood 21853 Way items death . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 ☐ Married Black, White, etc. or. δ 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. "natural", Spec/Black 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Rico Chemistry Co <u>Production Worker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ should be other traumatic Anna Collick Joshua McIntosh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Anna McIntosh/Mother B0101 Princess Anne, MD Kristwood Way, 21853 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Parsons Cemetery 12/18/2010 Salisbury, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bennie Smith 917 W. Isabella St. Salisbury, Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 23a. Part 14 Approximate Interval Between Immediate Cause (Final Onset and Death End Ph_sician/ disease condition resulting in death) Stage renal disease 5413 Medical Due to (or as a consequence of): **Examiner** Calciphylasi 145 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown the 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 🗆 Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performe director, page 2 certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Tes 2 X No 욘 1 Vinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.
Funeral Director; After 1 X Natural injury work?
1 Yes 2 No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check To the P within 2 only one 29b. Signature and tit e of 29c. License number 29d. Date signed (Month, Day, Year) 11/10 1+50457 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll St. 31. Date filed (Month, Day, Year) Y C C DO

32. Registrar's Signature 1der State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2010 1500 Luisa Milhan- Elad Maria Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick 1203 Little Brook Drive, Apt. B Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 05/06/196 1 M 2 XF Months Days Hours Min. Director Philippines 216-59-6576 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ms 23a or 28a-f sho must be notified at Director 1 🕁 Yes 2 🗌 No MD Frederick Frederick 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 1214 Palladian Wav <u>Philippines</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. ıral", or iteπ I Examiner π 11. Marital Status þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: Asian 3 Widowed 4 Divorced Completed er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Nursing Assistant <u>Health Care</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rosendo Millan <u>Isabel Pecson</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francisco Elad, Jr./ spouse <u> 1214 Palladian Way, Frederick, MD 21702</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery 12/27/2010 Frederick, MD 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service Licenses In MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) angino Medical Due to (or a a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed irector, page 2 should be de þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital: Other: 2 No 4 Nursing Home 5 Residence 6 2 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at self wit hanged 1
Natural 5 Pending December 202010 Unknown 1 ☐ Yes 2 XNo Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ryral Route Number, City or Town, State) determined 1203 Little Brook Drive Medical 29a. Certifier 🛄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Conbe Physician/ ZUIC 0530 Samuel Jacob Miller Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hage<u>rstown</u> Washington If Under 1 Social Security Number 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs. Funeral 1 X M 2 🗆 F Days Hours Min. July 13, 1916 Mary and Months 94 Yrs. Director 220-07-2153 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 Yes 2 XNo Md. Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral within 72 hours after death with 13175 Edgemont Rd. 21783 Examiner must U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 Yes 2 No Vas, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: "natural", Completed 3 ☐ Widowed 4 ☐ Divorced 43-46 White Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Tool Co. 8 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve ည Walter John Miller Annie E. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13185 Edgemont Rd. Smithsburg, Md. 21783 Jeffrey W. Miller (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Smithsburg Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 17, Smithsburg,Md. 2010 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg.Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACQUIRED PNEHMONIA a Community UNKHOWA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Day to (or as a consequence of): The law requires that the death certificate be executed physician and sthe burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) J Yes 2 □ No been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISEASE CORONARY ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No MAGETES MELLITUS 24a. Was an autopsy performed? Yes 2 No has page 2 certificate 25. Was case referred to medical Hospital or Attending Physician: director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA Certificate: To this funeral (Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident the 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and due to the cause 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 0058181 DECEMBER 15 2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 324 E. AMTIETAM ST #306 HAGERSTONN MD 21740 31. Date filed (Month, Day, 32. Registr#'s Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DEC. 22, 2010 Physician/ PHILIP BRENT MUDD 6:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES 2980 EUTAW FOREST DRIVE WALDORF If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday Funeral Months (Month, Day, Year) 6-20-1925 Country) 1 ▼M 2 □ F 85 219-12-3694 Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director CHARLES MD. WALDORF 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2980 EUTAW FOREST DRIVE 20603 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or ite the Medical Examiner Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married ARMY Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE KOREA "natural", 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry N.O.S. STATION U.S.GOVT Elementary/Seconday (0-12) College (1-4 or 5+) SUPERVISOR 12th n and Mental Hygiel Be 17. Father's Name (First, Middle, Last) 18. Mother's uen Surname should be file and Mental F ود 1 and 2 shc. • of Heath and اله. • em 27 is mark. • er traumatic ev. EUGENIA BRENT ပ FRANCIS RAYMOND MUDD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20646 10801 BRITTNEY LANE LA PLATA, MD. PHILIP MUDD, JR.-SON Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott ST.PETERS CEMETERY 1 KBurial 2 Cremation 3 Removal from State 12-29-10 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) MQ0479 . Signature of Funeral Service License 2 Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate FRA SIJ Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): nding physiciar Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown detached the 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be d 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: 4 Nursing Home 5 Residence 6 Nother (Specify) ASSIVES LIVE မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge red at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a dress of person who completed cause of d e 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 6:45PM Willie Nolen 12-17-2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2611 Afton Street Temple Hills Prince Georg's 5. Social Security Number 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 72 Yrs. Director 499-42-0480 8-8-1938 Wardell Missouri Usual Residence of Decedent Show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2611 Afton Street 20748 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes **2€**No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 X No. Specify: Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic National Geographic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Nolen Sr ဥ Lousier McClura 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Nolen, Wife Afton Street Temple Hills Md 20748 2611 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3,□Removal from State Maryland National Cemetery 12-29-2010 Laural Maryland 4 ☐ Donation 5 ☐ Other (Specify) un ral ervir 22. Name and Address of Facility Ronald M Taylor 11 Funeral Home 21. Signature 10583 Middleport Lane White Plains Md 20695 23a. Part1. Enter the disease, or comshock, or heart failure. List only fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DROW ARE HILTERY 45AN /Medical Due to (or as a consequence of) Examiner ARETES if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed 95L1P1 100 burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed cate has t page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1□ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) ¹√ Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification; Hospital or Attending 5 Pending 1 Natural nours after death.
neral Director; /
filled in by the fi investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

24 hours a To the l

completely

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, DEC 2 2 2010

Salman,

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 8830

DHMH 17 Rev 1/2001

Cameron

29c. License number

35656

29d. Date signed (Month, Day, Year)

Street #402 Silver Spring Maryland 20910

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PM :15 Maurice Edward Niblett, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** oasta bure 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 8. Date of Birth **Funeral** 1 🖾 M 2 🗆 F Months Days Hours (Month, Day, Country) Maryland Yrs 93 Director 220-10-9884 Usual Residence of Decedent items 23a or 28a-f show ler must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 K No DE Sussex Delmar 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 30025 Little Coach Lane 19940 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

Yes 2 No Black, White, etc. P. ģ 1 Never Married 2 Married 1944 Whether Aproved Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. "natural" Completed 3 Widowed 4 Divorced white 1945 the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) th and Mental Hygiene.

I is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Home Builder Construction Be Department of Health and Nental His Important: If item 27 is marked oth any injury or other traumatter. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sarah Elizabeth Donoway John Niblett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23456 2449 Hunting Horn Way Virginia Beach, VA Sheri Naumovic (granddaughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 2010 Delmar, Delaware Stephens Cemetery Dec. 16, . Signature of Funeral Service Licensee 22. Name and Address of Facility 13 East Grove Street Short Funeral Home Delmar, 19940 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one scuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ D10 a ISCHRMIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or imjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 5 Other (specify) sate has been signed by the spage 2 should be detached? 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → No 24a. Was an autopsy performed certificate Yes 25. Was case referred to medical director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital 1 Tyes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of completed filled in by the funeral 28d. Describe how injury occurred Natural iniury 5 Pending 2 🗆 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALY BULLY 30 202 Hugyan

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

UE

arke

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1:15 AM MADISON EDWIN OALS JR. Decembe 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Wicomico Salisbury Rehabilitation + Nursing Ctr lisbuce 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. **Funeral** Days 1 🛛 🛣 🗓 1 2 🗆 F Months Hours Min. DEC. 22, 1930 MARYLAND 79 Director 213-28-5392 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 No HARFORD MARYLAND HAVRE de GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 CONCOVE WAY 21078 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces ٥ 1 Never Married 2 Married ☐ Yes 2 XNo 1 ☐ Yes 2 XNo Specify. If Yes, Give WHITE 3 - Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HEAVY EQUIPMENT OPERATOR CONSTRUCTION 11 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MADISON SR. Ε. OALS NETTLE BAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s f Health a DIANA BANDJOUGH/DAUGHTER 107 CONCOVE WAY, HAVRE de GRACE, MD 21078 or other Baltimore, item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State CREMATORY OF DELMARV 12/17/10 5 Other (Specify) DELMAR, DELAWARE 22. Name and Address of Facility 21. Sign Service Lic U HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ - KE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burlal cal Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis ered filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be 1 Yes 2 14No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Year) 32 Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ OSCAR DAILY PEER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Western MD Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 □ F 03/09/1923 West Virginia **Director** 217-14-4480 87 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 X No WV Hampshire Springfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Green Spring Valley Road 26763 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 - Widowed 4 - Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Celanese Fibers Corp. 8 permit. Page 1 and 2 should be filed will Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, #1000. and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Harper Peer Eva White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Peer / Son Route 3, Box 93, Ridgeley, WV 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Forest Glen Cemetery: 12/23/2010 4 ☐ Donation 5 ☐ Other (Specify) Green Spring, WV 22. Name and Address of Facility Upchurch Funeral Home, Inc. 21. Signature of Coneral Service P.O. Box 1260, Fort Ashby, WV Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part 1 shock Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ evonan disease or condition 10 Medical resulting in death) Due to (or as a conse u ence of) Examiner Sequentially list conditions, if any, leading to immediate sause. Enter Onderlying Cause (Disease or linjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has ral director, page 2 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending work?
1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and hitle 29c. License number Dec 18,2010 D0033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland, MD 625 Avenue Kent State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2010 21:20 PM Eugene Clifford Pierce, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince George's Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 09-10-1946 North Carolina 242-78-9022 64 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County hours after death with the Maryland notified at Director 1 √2 Yes 2 ☐ No Prince George's Maryland Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ?7 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Apt. T2 Funeral 4421- Arnold Road 20746 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc 1 Never Married 2 X Married þ Specify: Black Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) D.C. Public Schools Custodian 12th and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Fannie Williams Linwood Pierce t. Page 1 and 2 should be rtment of Health and Men rtant: If item 27 is marke njury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arnold Road Apt. T2 Suitland, Maryland 20746 Andrea E. Fowler-Pierce 4421 / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Johnson Family Cem. 12-22-10 Halifax, North Carolina 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4308-Suitland Road, Suitland, Maryland 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** OPAT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir DISE sician and burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical WOHOUSM Box 68760 nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the a Id be detached fo a Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has bodies to be the autopsy death? 1 Yes 2 No 21 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 **D**No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral prompleted filled in prompleted filled 5 \square Pending iniury Natural 2 🗌 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day CONSUELLA DECEMBER 20 10:20AM PROCTOR 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11007 BELTON STREET UPPER MARLBORO PRINCE GEORGE'S 9. Birthplace (State or Foreign Country) NEW ORLEANS 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Director 439-55-8098 88 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a State 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director PRINCE GEORGE'S UPPER MARLBORO 1 Yes 2 □ No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö Funeral 23a USA 20774 11007 BELTON STREET 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ٥ 2 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK 3 → Widowed 4 □ Divorced If Yes, Give Specify 'natural", Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12TH RESTAURANT SERVICES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fired the second DAISEY ROBINSON UNKNOWN 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11007 BELTON STREET UPPER MARLBORO, MARYLAND 20774 BARBARA BECHET/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Page 1 permit. Page 1
Department of I
Important: If it
anxinjury or o 1 Burial 2 Cremation 3 Removal from State 12/28/2010 NEW ORLEANS, LA 4 ☐ Donation 5 ☐ Other (Specify) OLIVET CEMETERY J. B. JENKINS FUNERAL HOME, INC. Signature of Eunoral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final LUNG CANCER Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnan 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page 2 1 ☐ Yes 2 💢 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? 1 XYes 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural injury 5 Pending 2 🗌 No 24 hours after death. Funeral Director: A Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

7525 GREENWAY CENTER DRIVE #205 GREENBELT, MARYLAND 20770 WELTZ MARTIN 31. Date filed (Month, Day, Year) OEC 2 3 2010 32. Registra s Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10120 4100

2 [3 [29b. Signature and title of certifier

29c. License number

D23743

29d. Date signed (Month, Day, Year)

DECEMBER 21, 2010

Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per PHY G911 1/13/2011 JH State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Tivadar Petrus Physician/ Month Da Tivodor W. Petrus 10:26 Ам 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Brentwood 4509 38th Place 9. Birthplace (State or Foreign Country) Romania 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Min. 1 🖾 M 2 🗆 F Hours 469-02-6719 Director 69 Yrs 1941 January Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b, County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Prince George's Brentwood 1 X Yes 2 No Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4509 38th Place 20722 USA death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 🔀 No filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed Home Improvement Contractor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (Unav.) (Unav. . Page 1 and 2 should ment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsa Carrion Petrus / Wife 4509 38th Place, Brentwood, MD 20722 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or c 1 X Burial 2 Cremation 3 Removal from State Brentwood, Maryland 12/28/2010 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 4739 Baltimore Avenue 21. Signature of Emeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on e and line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and/Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a cons and nce of) burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the as 1 attending E FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? fo Year Month Day 5 Other (specify) Pregnant at time of death Yes 2 □ No the detached g Unknown g | Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law Jas page 2 autopsy performed Yes 2 certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending work 1 ☐ Yes 2 ☐ No Accident Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 🗌 Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

31. Date filed (Month, Day, Year DEC 2 3 2010

29b. Signature

and title of certified

1

MID Emmer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

Pamaria

005120

29d. Date signed (Month, Day, Year)

2010